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NURSES' PERCEPTIONS OF THEIR ROLES AND FUNCTIONS IN THE EMERGENCY ROOM

©

by

LORNA M. BELL

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NAME OF AUTHOR: LORNA M. BELL

TITLE OF THESIS: NURSES' PERCEPTIONS OF THEIR ROLES AND FUNCTIONS IN THE EMERGENCY ROOM

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Signed: Lorna M. Bell

PERMANENT ADDRESS:

5708 49 AVENUE
LACOMBE, ALBERTA TOC 1S0

Dated: July 30, 1988

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled NURSES' PERCEPTIONS OF THEIR ROLES AND FUNCTIONS IN THE EMERGENCY ROOM submitted by LORNA BELL in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

Peggy Anne Field

(Supervisor)

Stacey Lewis

Kyung Bell

Date: 26 July 1988

DEDICATION

To my husband Cyrus
who has helped me achieve this goal.
To my children Joleen,
who is always at my side,
Benjamin and Ashley who will
never know my tribulations,
and my parents for their
belief in me.

ABSTRACT

The purposes of this study were to determine the present roles and functions of the Emergency Room (ER) nurse, the adequacy of educational preparation, the need for additional knowledge and skill, and the perceived level of satisfaction. Instrumentation consisted of a biographical data sheet and a four part nursing function questionnaire which were distributed to respondents. Content and face validity were established, and reliability of the tool was found to be within acceptable limits. Ninety ER nurses from three hospitals in a city in Western Canada completed and returned the questionnaires. Factor analysis was carried out to determine the construct validity of the questionnaire. The categories of non-nursing functions, critical care functions, and new nursing functions, established from the literature review, were confirmed as major clusters of nursing functions. The respondents reported that they continue to perform non-nursing functions frequently and express dissatisfaction in doing so. Although ER nurses do not perform critical care functions frequently, they expressed a need for more knowledge and skill, but at the same time stated their training was excellent and that they were very satisfied with their critical care role. Nurses were performing some new nursing functions frequently although they state that written care plans are not being used. They expressed a need for more information about new nursing functions, specifically with regard to care of the chronically ill patient. It

was evident that nurses had assumed some functions consistent with an expanded nursing role, but continued to perform many functions characteristic of the traditional ER nursing role. There were significant differences between degree and non-degree nurses in the satisfaction with performance of non-nursing functions, between new and experienced graduates in the need for additional knowledge in performing new functions, and between hospitals in the frequency of performing non-nursing functions.

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CHAPTER I

STATEMENT OF THE PROBLEM AND ITS SIGNIFICANCE

Introduction

The Emergency Room (ER) is one continually available point for those who seek access to health care facilities. The ER nurse plays a key role in the care of the ill or injured patient (Barry, 1978). The wide variability of patient acuity and the stochastic workload demand high levels of skills and expertise for each member of the ER health care team (Parker, 1984).

Changing ER utilization patterns have been evident in the past two decades (Davidson, 1978; Laufman, 1981; Pisarcik, 1980; Stratman + Ullman, 1975). The ER client population continues to rise (Kluge, Wegryn + Lemley, 1965; O'Boyle, 1972; Riffer, 1986; Roth, 1972), and the largest majority of users are those patients with non-urgent conditions (Andren + Rosenqvist, 1986; Bartolucci + Drayer, 1973; Coleman + Errera, 1963; Lavenhar, Ratner + Weinerman, 1968; Small + Seime, 1986). The effect of this change on the role and functions of the ER nurse has not been clearly identified (Baker + Moynihan, 1983; Cosgriff, 1974; Jones, Yoder + Jones, 1984; Novotny-Dinsdale, 1985; Taylor, 1984).

In the traditional role of care giver, ER nurses functioned in a task-oriented system which required critical care nursing skills. Matters of highest importance were given priority attention

while less urgent tasks were left undone until a nurse became available (Blair, Walts + Thompson, 1982; Thompson, 1986). Although care was often fragmented and impersonal (O'Boyle, 1972; McCall + O'Sullivan, 1982; Taylor, 1984; Toohey, 1984; Tucker + Deaver, 1986), nurses enjoyed the varied pace and the challenge inherent in the care of the physically traumatized patient (Burns, Kirilloff + Close, 1983; Lewis + Bradbury, 1983; Mytych, 1983). Additionally, nurses spent large portions of work time performing non-nursing tasks (Gray, 1976; Mellett, 1981; Parker, 1984).

The new role of the ER nurse has been expanded to encompass broader components where nurses must function both as critical care and non-critical care specialists. To meet the needs of the large numbers of non-urgent patients, ER nursing care should now include aspects of preventive health care, patient/family teaching, and appropriate nursing referrals for continued care (Budassi Sheehy + Barber, 1985; Parker, 1984).

New standards for care have recently been established which reflect the expanded role of the ER nurse in the 1980s (Emergency Department Nurses Association, 1983; National Emergency Nurses Affiliation, 1986). Nurses, however, state that they have not been given the opportunity to upgrade knowledge and skills for a changing nursing role (O'Boyle, 1972; Fincke, 1975; Romano, 1975, 1978). Also there is some indication that nurses are reluctant to perform nursing care in an expanded role (Blair, Sparger, Walts + Thompson, 1982; Jones, Yoder + Jones, 1984).

Purpose

The purposes of this study were to determine (1) the present role(s) and functions of the ER nurse, (2) the adequacy of educational preparation for ER nurses in performing selected roles and functions, (3) the need for additional knowledge and skill, and (4) the level of satisfaction in performing nursing roles.

Statement of the Problem

During the last two decades, the health care needs of the increasing numbers of non-urgent ER patients have necessitated an expansion in the role and functions of the ER nurse. New standards have been established which identified the components of a broadened nurse role, although there has been no recent attempt to determine what role(s) and functions the ER nurse is actually performing. There was some evidence in the literature to indicate that nurses were confused about their new role and that they did not feel they had been given the opportunity to upgrade knowledge and skills for a changing nursing role. This study was therefore designed to examine nurses' perceptions of the functions they perform in the ER setting and to determine whether nurses perceive a need for additional education to perform selected nursing functions.

Research Questions

This descriptive study addressed the following questions:

(a) To what extent are ER nurses performing selected nursing functions?

(b) Do ER nurses have adequate training to perform selected nursing functions?

(c) Do ER nurses express a need for additional knowledge and skills to perform selected nursing functions?

(d) Are ER nurses satisfied with selected nursing functions presently being performed?

Operational Definitions

Traditional nursing role: the role of the nurse based on selected aspects of care of emergent and urgent patients and identified non-nursing functions as measured by questions on the nursing function questionnaire.

Expanded Nursing role: the role of the nurse based on selected aspects of care of the non-urgent patient as measured by questions on the nursing function questionnaire.

Nursing functions: selected nursing activities performed by the nurse as part of her role measured through selected activities on the nursing function questionnaire.

Emergent patient: classified as the patient who required immediate medical attention. (Lavenhar, Ratner, Weinerman, 1968).

Urgent patient: classified as the patient who required medical attention within a few hours. (Lavenhar, Ratner, Weinerman, 1968).

Non-urgent patient: classified as the patient who did not require the resources of an ER physician or the ER facilities. (Lavenhar, Ratner, Weinerman, 1968).

Assumptions

The following assumptions were made with regard to the study:

1. The role of the ER nurse in the 1980s is undergoing change.

2. The role and functions of the ER nurse have not, to-date, been clearly identified.

Deliminations

The deliminations of this study are as follows:

1. The main purpose of this study was to describe the role of the ER nurse. In order that further comparisons could be made between nurse groups in functions being performed, ordinal level data were assigned interval scale qualities, and some association testing was done.

2. A non-probability sampling method was used which limits the generalizability of results to the ER nurse population in Western Canada.

Summary of Chapters to Follow

An extensive literature review of work published in English and relevant to this topic and the conceptual framework of this study are presented in Chapter 2. The method is described in Chapter 3, and the results of the data analysis are presented in Chapter 4. A summary, discussion, and conclusions comprise Chapter 5.

CHAPTER II

REVIEW OF RELATED LITERATURE RESEARCH

The literature review is divided into three sections. In the first section, a review of the emergence of the nursing role concept is provided. In the second section an overview of studies on the roles and functions of the ER nurse is presented; the theoretical framework is located in the third section.

Emergence of the Concept of Nursing Role

Attempts to address the concept of nursing role have been numerous. According to some writers (Castledine, 1983; Coler and Sutherland, 1983; Downie, 1984; LaRocco, 1978; Noth, 1973; Singleton + Nail, 1984; Torres, 1974) the concept of role is itself a highly ambiguous term and the difficulty in defining role only adds to the plight of the nurses in their search for a strong role identity. For the purpose of this study, role will be conceptualized as the part an actor plays in a given setting (Wyld, 1932). Functions are defined as those actions performed by the actor in assuming the role (Wyld, 1932).

Changes in the development of the nursing profession have been closely allied with the rising social status of women (Bullough + Bullough, 1967; Kalisch + Kalisch, 1977, Lovell, 1981). Probably the earliest and most important influence on the nursing occupation was the work of Florence Nightingale. Contributions made by Nightingale to nursing were an improved attitude toward the nursing profession, the establishment of a new occupation for women,

increased education for nurses, and improved standards for nursing care. Nursing at this time was focused on caring for the needs of the ill with special regard to environmental conditions (Nightingale, 1860).

In the 1900s, nursing schools flourished and committees were formed to set standards, establish functions, and to define the practice of nursing. According to the American Journal of Nursing (1933), nursing was interpreted as "a social institution whose primary purpose was to promote and restore bodily well-being, including physical, mental and social well-being" (p.565). Taylor (1934) emphasized a positive change in the focus of nursing from reparative to one of health maintenance and promotion.

The mid-1900s marked a period of time where nursing began to seriously examine its structure in the health setting. New science and technology revolutionized the health industry and the medical profession took great strides in knowledge and research in the medical field. Nurses, too, were eager for changes, however the path for them was less clear. According to Nuckolls (1974) and Peplau (1977) nurses had suddenly become powerless in a changing system and this period marked the beginning of the identity crisis.

Nurses were being questioned about their professional status (Bernays, 1946; Devreux, 1950), and sociologists were called upon to help nurses clarify their role and purpose in the health setting. According to Tatum (1953), nursing role problems were complicated by a multitude of roles and relationships within the hospital hierarchy. Other sociologists analyzed nursing in terms of a three way relationship where the doctor dominated over a patient-nurse-doctor

triad (Johnson + Martin, 1958).

Nurses were left to pick up many newly arisen non-nursing tasks (Davis, 1974; Gordon, 1953; Peplau, 1977; Tatum, 1953). Other complicating factors included the idea that nurses were caught between conflicting expectations of the hospital bureaucracy (Etzioni, 1959., Scott, 1966), devotion to patients (Thorner, 1955), and physician domination (Kalisch + Kalisch, 1977; Lovell, 1981; Nuckolls, 1974; Partridge, 1978).

In the 1960s, the supply of and demand for nurses were rising, but the role of the nurse was no clearer (Henderson, 1964). An emphasis was placed on a more autonomous nursing role which shifted away from care of the curative physical bodily responses to a psycho-social patient orientation.

Bates (1970) wrote of the lack of success nurses have had in developing an autonomous role. Nurses continued to priorize technical procedures over personal patient contact (Duff + Hollinshead, 1968), and the poor nurse/physician relationship continued to create dysfunctional consequences on patient care (Holfing, Brotzman, Dalrymple, Graves + Pierce, 1966). Stein (1967) laid equal blame on the physician who played partner in a doctor-nurse game and who was unable to function in an effective working relationship with the nurse. According to one poll which surveyed both the public and the medical profession (Lee, 1979), nurses in the 1970s continued to function as handmaiden to the physician and the ability of nurses to contribute professionally to the health team was being questioned.

Within the last two decades, several issues were prominent

in the literature. The idea of specialization was thought to be, by some writers, an indication that the profession had advanced to the point where particular aspects of clinical nursing practice could provide a focus for analyzing nursing roles (Murphy + Hoeffer, 1983). Other authors wrote that the professional nurse role must first be clearly outlined before proliferation of new roles could become a reality (Noth, 1973; Singleton + Nail, 1984). Rogers (1972) cautioned nurses about the dangers of specialization and warned that many new nursing functions merely filled technological medically delegated demands which returned nurses to their previous handmaiden image.

To compound the problems already inherent in delineating the role and functions of the nurse, a new role was being considered, that of an expanded nursing role. Such a role would allow nurses to have more responsibility and opportunity to meet the increasing demand for health care (Secretary's Committee to Study Extended Nurse Roles, 1972). The committee reported that the role of health workers had changed to provide a health maintenance promotion and illness prevention focus. Although a clear definition of expanded role and its components were not presented, the report recommended that nurses expand their role by broadening both knowledge and skill and seek together with other workers the highest level of competence. Some acknowledgement was given to the ideas of continuing education to prepare presently employed nurses and better documentation of new or changed nursing skills.

The only study found in the review of the literature where specific functions characteristic of the evolving nurse role were

identified was conducted by Torres (1974). The author commented on the variety of new established roles for the nurse with little if any understanding of the functions which would be performed in response to the changing roles. Nurse educators in this study identified nursing functions and categorized them according to the steps of the nursing process. They predicted that 70% of nurses would be performing the nursing functions within the next decade. Torres (1974) concluded that further exploration and identification of the specific functions of the professional nurse were needed if nurses wish to meet with health needs of society now and in the future.

According to Kellar (1973), Nuckolls (1974) and Singleton and Nail (1984), many nurses who function in expanded roles continue to function under physician-delegated authority due to many gray areas where transfering of responsibilities between doctor and nurse have not yet been defined. Other factors which inhibited nurses from assuming expanded roles were the workplace, co-worker, the health consumer, and the nurse herself (Nuckolls, 1974).

The idea of expanded nursing roles has not been clearly defined nor has there been unanimous agreement. Kellar (1973) spoke of the shrinking role of the nurse in which traditional nursing functions were being taken over by more cost-effective workers. She concluded that the professional nurse would not continue to be a viable member of the health team because new specialities were taking over much of the tasks a nurse once performed.

As of 1970, physicians in the United States proclaimed they would facilitate the expansion of the role of the nurse (JAMA, 1970). A more recent article published in a Canadian journal indicated that

physicians were questioning an additional and unnecessary layer to the health system and expressed concern that the concept of expanded roles was poorly defined (Henderson, 1983).

Some of the most recent studies conducted on the attitude of nurses towards more autonomous nursing roles were those of Weiss (1983; 1984; 1985) and Weiss and Reimen (1983). A large group of nurses was studied over a 20 month period during which interactions with consumers and physicians were monitored. In analyzing the data, researchers documented that the majority of nurses were not able to clearly articulate their role in the health setting. Nurses were unable to identify strongly with their profession and could not delineate the boundaries of nursing. Although the nurses expressed a desire for greater recognition and power, at the same time they expressed discomfort with the idea of increased responsibility. Weiss (1984; 1985) concluded that nurse role behavior was deeply internalized by nurses and that more autonomous roles could only be acquired through re-education and facilitation of new knowledge and skills for nurses. Similarly, Sands and Ismeurt (1986) studied powerlessness among 125 staff nurses and found that not only did nurses express high feelings of powerlessness but only a small percentage of nurses expressed a desire for more responsibility in the work setting.

The Roles and Functions of the ER Nurse

Many changes have taken place in the area of emergency health care in the last two decades. What was formerly known as an ER has become a larger department equipped to handle major trauma, care of the critically ill, and care of the large numbers of

non-urgently ill patients (Davidson, 1978; Laufman, 1981; Pisarcik, 1980; Stratmann + Ullman, 1975). Health consumers appear to prefer the emergency department facility over the doctor's office, as indicated by an increasing number of visits to the ER each year (Hilker, 1978; Kluge, Wegryn + Lemley, 1965; Pisarcik, 1980; Riffer, 1986). It has become evident that increasingly larger numbers of people are using the department as a community centre for outpatient care (Bartolucci + Drayer, 1973; Laufman, 1981; Roth 1972; Seim + Small, 1986). The largest majority of patients are the non-urgent users including those in need of psycho-social support (Andren + Rosenqvist, 1986; Coleman + Errera, 1963; Jacoby + Jones, 1982, Jones, Yoder + Jones, 1984; Kirkpatrick + Taubenhaus, 1967; Lavenhar, Ratner + Weinerman, 1968; Pisarcik, 1980; Stratmann + Ullman, 1975; Torrens + Yedvab, 1970).

The field of ER nursing has gained increased recognition as a specialty over the last decade (Budassi Sheehy + Barber, 1985). According to Parker (1985), the ER nurse specialty is characterized by a "brevity of patient interaction, a stressful climate created by an inability to control the number of patients seeking care, and a limited time frame in which to evaluate the effectiveness of intervention" (p.8). The ER nurse has been identified as the generalized specialist who must practice all nurse specialties at a variety of different levels under many different circumstances (Budassi Sheehy + Barber, 1985; Hammond + Lee, 1984). In this literature review there is a clear indication that the role(s) and functions of the ER nurse have never been clearly identified.

The traditional role of the ER nurse is not clearly defined

in the literature. Some writers spoke of the non-nursing activities of the traditional ER nurse. Duties included scrubbing floors and walls, maintaining equipment, ordering and stocking supplies, collecting patients' clothing and property, shuffling patients, registering patients, and calling, waiting on, and assisting the doctor. Some time was spent performing care for the emergency patient (Gray, 1976; Mellett, 1981; Parker, 1984).

Gray (1976) studied ER nurses to determine the portions of working time spent on performing nursing and non-nursing functions. The author concluded that 78% of nursing time was spent on non-nursing duties, which included secretarial, nurse's aid and orderly duties. This study was followed up by Mellett (1981) who analyzed ER nurse functions in a qualitative study. Activities were categorized according to dependent and independent nursing functions, and secretarial, housekeeping, and transportation functions. Nurses in this study spent a total of 53% of work time performing nursing functions. The remainder of time (47%) was spent performing non-nursing functions with 22% of time being spent on "waiting for physician arrival". Both authors concluded that increasing nurse availability to the patient would improve the quality of nursing care and improve job satisfation for ER nurses.

According to Blair, Sparger, Walts and Thompson (1982), the idea of improving nursing care through careful patient assessment was only a myth because the method of organizing and delivering nursing care had not changed to meet the needs of the changing clientele. Nurses continued to function under a team method of nursing which allowed for accomplishment of high priority tasks resulting in

fragmented impersonal care (McCall + O'Sullivan, 1982; Taylor 1984; Thompson, 1986; Toohey, 1984; Tucker + Deaver, 1986).

Jones, Yoder and Jones (1984) documented an additional side to the traditional ER nurse role. Nurses in this study preferred their traditional ER nurse role which was to care for the urgent or emergent patient who was physically traumatized or acutely ill. Lavenhar, Ratner and Weinerman (1968) differentiated between urgent, emergent and non-urgent patient types. The urgent patient was classified as the patient who required medical attention within a few hours, whereas the emergent patient required immediate attention. The non-urgent patient did not require the resources of an ER physician or the facilities of an ER room. It is assumed, then, that the traditional ER nurse role consists of performance of non-nursing functions and care of the urgent or emergent physically traumatized or acutely ill patient.

The ER nurse is now classified by some authors as a specialist with new roles and responsibilities. The new role of the ER nurse specialist has expanded to include not only critical life-saving care, but also care of the large numbers of non-urgent patients including aspects of preventive care, patient/family health education, and appropriate nursing referrals for continued care (Budassi, Sheehy + Barber, 1985; Emergency Department Nurses Association, 1983; Parker, 1984; National Emergency Nurses Affiliation, 1986). The components of the expanded role of the ER nurse have been carefully outlined in new standards developed by the Emergency Department Nurses Association, 1983 (see Appendix A).

According to the new Standards for Emergency Nursing

Practice (Emergency Department Nurses Association, 1983):

> The scope of emergency nursing practice encompasses nursing activities which are directed toward health problems of various levels of complexity. A rapidly changing physiological and/or psychological status which may be life threatening, requires assessment of the severity of the health problem, definitive intervention, ongoing reassessment, and supportive care to significant others. The level of physiological and/or psychological complexity may require life-support measures, appropriate health education, referral, and knowledge of legal implications (p.31).

Jones, Yoder, and Jones (1984) and Yoder and Jones(1981) studied ER nursing personnel from several emergency settings to assess the expectations and job goals of nurses in the 1980's. Nurses in these studies held initial expectations which were that nursing time would be spent performing life-saving measures on the emergent physically traumatized patient. The researchers concluded that nurses were experiencing a role dilemma because they continued to define their job in terms of the traditional ER trauma patient who, in reality, constitutes only a small percentage of the ER population. The nurses expressed a dislike for the large numbers of non-urgent patients especially those in need of emotional or psychosocial support who would present with non-specific problems demanding careful nursing assessment, intervention, teaching, and follow-up.

Emergency Room nurses have stated that they have not been given the opportunity to upgrade knowledge and skills to meet new patient needs (Barry, 1978; Fincke, 1974; Romano, 1975, 1978). Barrows (1985) documented in a survey study that 90% of nurses in 26 emergency departments had received no formal education in physical assessment of the ER patient. Of those nurses who completed a

program on in-depth history taking, physical assessment, and documentation, only 50% of nurses reported they were able to use those skills in the ER setting. Obstacles identified which prevented implementation of skills were a lack of support from other hospital workers including supervisors, administrators and physicians.

According to Parker (1984), the predominant issue which blocks nurses from assuming an expanded nursing role is the lack of standardization and the lack of a collective vision for care of the ER patient. Andreoli and Musser (1985) attribute some of nursing's role-related problems to a professional lethargy among nurses themselves, as indicated by a low representation in their professional nursing organization.

Documentation of any system for nursing care has only recently been advocated in the literature (Blair, Sparger, Walts + Thompson, 1982; McCall + O'Sullivan, 1982; Novotny-Dinsdale, 1985, Taylor, 1984; Thompson, 1986; Tucker, 1986). Of those studies done, no documentation of reliability or validity of data gathering tools was provided nor has any recent attempt been made to study the functions being performed by the ER nurse in any role.

Conclusions

Nurses have struggled over the last 100 years to achieve a strong professional identity. Although many writers have attributed different causes to the problems being experienced by nursing, all were in agreement that problems relating to the role(s) and functions of the nurse were evident. In the last decade, the idea of a more autonomous role for nurses has become prominent. Many authors have discussed the concept of an expanded and autonomous nursing role,

however only in one study (Torres, 1974) were the functions of the professional nurse in such a role actually identified. In this study, the author emphasized that clearly established functions must accompany all role changes if nurses are to meet the future health needs of society. Nurses themselves are unclear of their future role and purpose in the health setting, and many nurses have expressed their reluctance to assume an expanded role.

Changes in the emergency health care setting have added to the plight of the ER nurse in search of a strong role identity. Where the traditional role of the ER nurse consisted of many non-nursing functions and care of the critically ill or injured patient, the new role of the nurse has expanded to care for the increasingly larger numbers of non-urgent patients. New standards have been established which specify nursing activities directed at health problems with varying complexities. Nurses, however, prefer to think of their role as traditional trauma nurses, and have expressed some reluctance to reorganize nursing care and assume new functions in caring for the non-urgent patients. There has been no recent attempt to study the roles and functions of the ER nurse.

Conceptual Framework

To mitigate the gap in knowledge noted in the review of the literature, this study addressed nurses' perceptions of their role(s) and functions when providing nursing care for ER patients. To differentiate between role(s) and functions, role will be defined as the part played by an actor in a given setting; whereas functions are defined as those actions performed by the actor in such a role (Wyld, 1932). The nurse, then, performs functions as part of her

role in the ER setting.

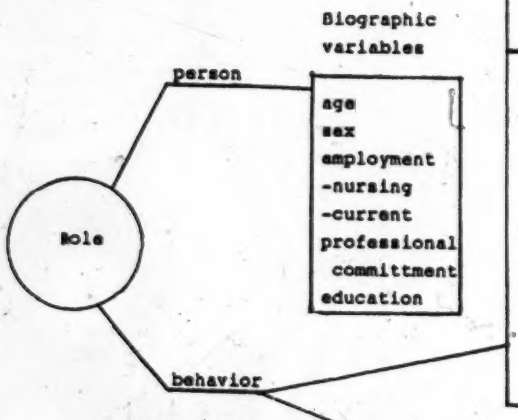
Thomas and Biddle (1966) provide a framework to classify role phenomena. The authors describe the field of role study as a combination of the person/behavior concept. Specific interest lies with persons being studied in a given setting. In the present study, biographic data provided the investigator with specific information about subjects including age, sex, education, employment and professional commitment (see Figure 1). Behavior refers to those concepts relating to the execution of required functions including "action, description, evaluation, prescription and sanction" (p.25).

In the profession of nursing, Torres (1974) categorized nursing behaviors according to the five major aspects of the nursing process, namely, data gathering, diagnosis, intervention, evaluation and administration. Specific nursing functions were identified within each category. Vacek, Ashikaga, Mabry and Brown (1978) developed a similar model on which nursing behaviors could be based using the major components of the nursing process. Additionally, specific nursing functions could be categorized by nursing process components.

In the current study, the role(s) and functions of the ER nurse have been examined. A review of the literature showed that the traditional role of the ER nurse included performance of non-nursing functions, and care of the critically ill or injured patient (Figure 1). The more recent role of the ER nurse has expanded to include aspects of preventive health care, patient teaching and nursing referrals. The new nursing role has developed out of the need for nurses to care for the increasing numbers of patients who come to the

Figure 1

Selected Components of a Traditional ER Nursing Role



**Nursing functions - Care of urgent/emergent patients

simultaneous and ongoing

Assessment	Plan of Care	Intervention	Evaluation
Perform the ABCs (airway, breathing, circulation) of emergency assessment in the seriously ill or injured patient.	Independently diagnose and initiate care for a patient with an acute condition based on signs and symptoms. Draw up treatment and management plans for the acutely ill.	Respond to a patient who is admitted to the department in full cardiac arrest by initiation of CPR. Assist in the emergency defibrillation of a patient who is admitted in full cardiac arrest. Assist in applying anti-shock trousers (MAST) to control bleeding in a traumatized patient.	A. Nurse Need for more knowledge or skill. Satisfaction with nursing performance. B. Patient

*Non-nursing functions

Secretarial

Complete patient requisition forms.

Transportation

Porter patients via stretcher to other hospital areas.

Move patients and belongings around the emergency department.

Housekeeping/Maintenance

Phone or search floors for missing equipment.

Restock emergency room with linens.

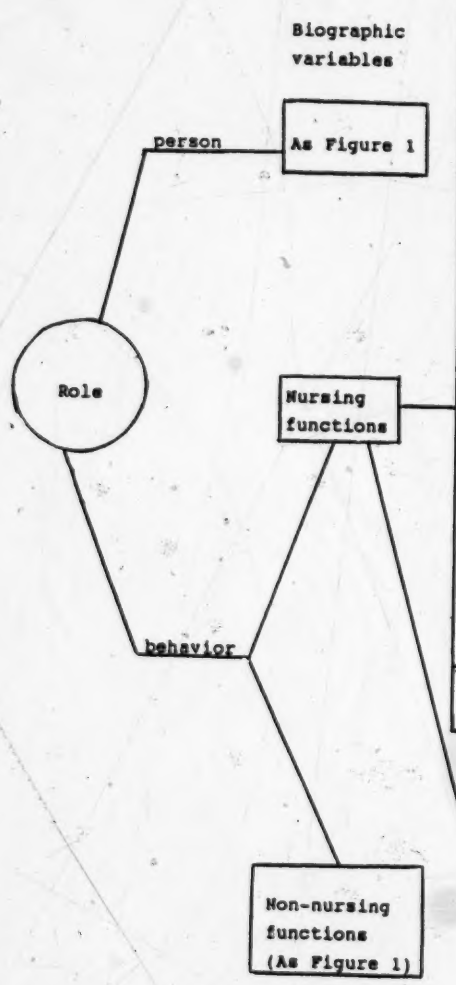
department with non-urgent health needs. The components of an expanded nursing role, based on the nursing process, are illustrated in Figure 2.

All functions within each component are consistent with the standards established for emergency nursing practice (Appendix A). It should be noted that in a traditional role, nurses performed both non-nursing functions and nursing care for urgent patients (Figure 1). In Figure 2, it is shown that nurses must now assume additional responsibilities in caring for the non-urgent patients.

The concept of an expanded ER nursing role is presented in Figure 3. The ER nurse's role is conceptualized as a person/behavior combination. The person concept is represented by nurse biographical data. Nursing behaviors consist of both non-nursing and nursing functions. Within the nursing functions, a framework provides for care of both the urgent and non-urgent patient. For example, in caring for the urgent patient, nurses who function in expanded roles may perform the ABC's of emergency assessment. As well, nurses may be called upon to care for the non-urgent client in planning for treatment of minor or chronic illness. Finally, nurses may be asked to perform non-nursing functions in transporting patients to other hospital areas. The activities of a nurse performing in both traditional and expanded roles are presented in Table 2.1. Functions have been delineated into traditional and new functions to assist the reader's grasp of the broadened components in an expanded role. At this time of role change for the ER nurse, it seems important to determine what aspects of the expanded role ER nurses perceive themselves to be performing in an actual health setting.

Figure 2

Selected Components of an Expanded ER Nursing Role



Care of non-urgent patients

Evaluation a. Nurse - Satisfaction with nursing functions; Need for additional knowledge and skill b. Patient - Follow-up care, referrals			
Assessment	**Analysis**	**Planning**	**Intervention**
- Obtain a health history - Obtain patients' perceptions of health problems - Obtain physical data base - Obtain information about the physical environment - Assess health habits - Evaluate patients' home and family setting (economic, cultural, religious factors)	- Identify health problems - Share in arriving at diagnosis - Perform laboratory tests	- Plan treatment for minor and chronic illnesses - Plan methods to motivate patients to practice preventive health care - Determine methods/ways to motivate patients to adhere to presented plan of care - Establish a written plan of care	- Instruct a patient about the use, mode of action, side effects of medication - Teach/counsel a patient about a chronic condition - Teach/counsel a patient on ways of obtaining a sense of wellness - Help patients to adapt to specific health problems - Practice preventive health care - Provide health education
Communication - Patient family, ER team, community			

Critical care of Urgent/Emergent Patient (as Figure 1)

	simultaneous and ongoing		
Assessment	Plan for Care	Intervention	Evaluation

Figure 3

Concept of an Expanded ER Nursing Role

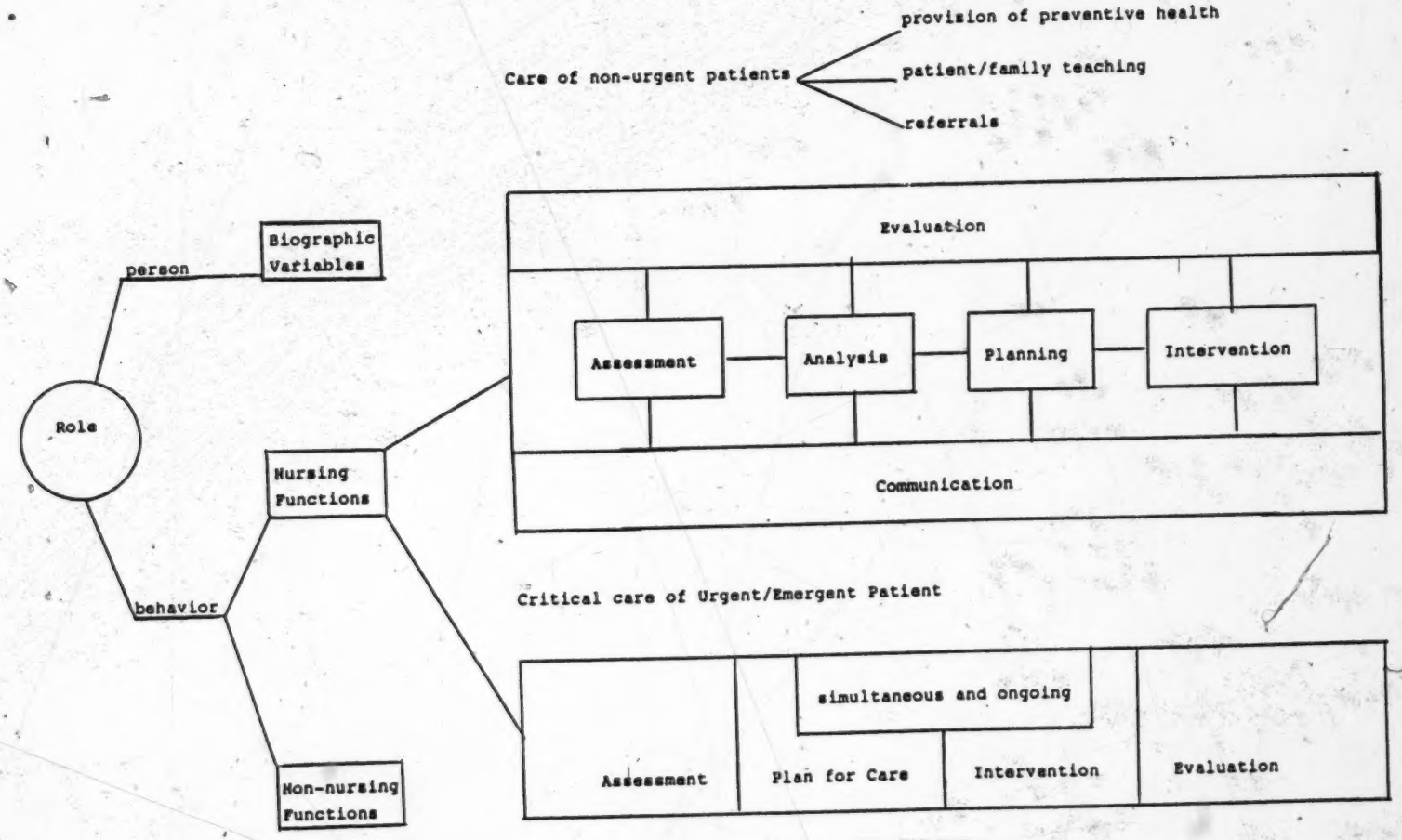


Table 2.1
Emergency Room Nursing Role

Traditional Functions	New Functions
a. Nursing -Perform the ABCs (airway, breathing, circulation) of emergency assessment in the seriously ill or injured patient. -Independently diagnose and initiate care for a patient with an acute condition based on signs and symptoms. -Draw up treatment and management plans for the acutely ill patients. -Respond to a patient who is admitted to the department in full cardiac arrest by initiation of CPR. -Assist in the emergency defibrillation of a patient who is admitted in full cardiac arrest. -Assist in appying anti-shock trousers (MAST) to control bleeding in an acutely traumatized patient.	a. Nursing -Establish a written plan of care for a patient with a presenting complaint. -Obtain, as part of a history, a patient's perception of his problem and how it affects his life. -Assess a patient's general health habits. -Obtain information about the physical environment of the home and community. -Evaluate economic, religious, and cultural factors for their impact on family and community health. -Counsel a patient about available community resources that might be relevant to his needs. -Instruct a patient about the use of medications (e.g. mode of action, side effects). -Perform an initial physical examination in assessment of the non-critical patient. -Counsel and teach a patient/family about the nature of his chronic condition.

Table 2.1
(continued)
Emergency Room Nursing Role

Traditional Functions	New Functions
	a. Nursing -Counsel a patient on ways of obtaining a sense of wellness in the presence of a chronic condition.
b. Non-nursing -Search on nursing floors and other areas for missing equipment. -Transport patients via stretcher to other hospital areas. -Move patients and belongings around the emergency department. -Restock linen in emergency rooms -Complete requisition forms (lab work).	

CHAPTER III

METHOD

Design of the Study

This study was designed to measure and describe ER nurses' perceptions of their roles and functions in the ER setting. A descriptive study design was utilized whereby ER nurses currently employed were asked to evaluate their performance according to frequency, extent of training, need for additional knowledge, and satisfaction with functions being performed.

Setting and Sample

The target population for this study was registered nurses currently employed in ER nursing. Given practicality and cost constraints, the study population consisted of the full time and part time (16 hours of work per week or more) nursing staff from the emergency departments of three general hospitals in a city in Western Canada.

Procedure

Data were collected from respondents by the use of a questionnaire. Following permission to conduct the study in the three hospitals, unit supervisors were approached and the research plan outlined. Upon request, the questionnaire packets were left with the unit supervisors to hand distribute to potential subjects. A quarantee of anonymity, confidentiality and the right to refuse to participate in the study was carefully outlined to the nurses in the

letter of explanation contained in each packet (Appendix B). Voluntary completion of the questionnaire was considered to be the nurse's consent to participate in the study.

Instrumentation

Development of the Instrument

The instrument used consisted of a two-part questionnaire which was modified from a larger tool developed by Vacek, Brown and Ashikaga (1979); the original tool was designed to study the role of nurse practitioners and registered nurses in an ambulatory care setting. The first part of the instrument was designed to obtain biographical information from the subjects and the second part measured the functions that ER nurses perceive they undertake in providing patient care in the emergency setting.

1) Biographical questionnaire. The biographical questionnaire used was a self-administered 6-item instrument which gathered data on the variables age, sex, education, general work experience, experience specific to the present employment, and professional commitment (Appendix C).

2) Nursing function questionnaire. Four scales were selected and modified from the Vacek, Brown and Ashikaga (1979) tool. The original tool contained 12 lengthy scales which measured the effect of nursing functions on: cost, quality, and availability of health care; auditing practices; problems in providing nursing care; confidence; cost-effectiveness; satisfaction with nursing roles; need for additional knowledge and skill; and frequency and extent of training in performing selected nursing functions. The latter four scales, namely, satisfaction with nursing roles, need for

additional knowledge and skill, frequency of performance of skills, and extent of training, were selected from the larger tool because they related specifically to the research questions rasied in this study. Permission to use the tool was obtained (Appendix D).

In a review of the literature, a list of functions relating to three aspects of the ER nurses' role had been developed. These functions were compared with the items in the questionnaire developed by Vacek et al (1979). The questionnaire was revised to ensure that it was compatible with Canadian Emergency Room Nurse Practices and also with the standards and practices identified in the literature. For the four scales used from the original tool, content validity was established by a panel of experts consisting of a medical sociologist physician, two faculty of nursing members and a statistician. The tool was also pretested using eight nurses from a variety of practice settings. A further measure of validity consisted of an interview with the eight nurses following completion of the questionnaire to verify the consistency of responses. The Spearman-Brown formula was used to estimate reliability. Reliability coefficients reported by Vacek et al (1979) for those scales used in the study were: frequency of performance of selected nursing functions .52 to .80; extent of training .30 to .82; need for additional knowledge and skill .88; satisfaction with nursing roles .80.

For the purpose of this study, the questions deleted from the four original scales were those which related specifically to the role of the nurse practitioner, or those questions which did not allow for differentiation between ER nurses in traditional and expanded roles. Those questionnaire items which related specifically

to traditional nursing functions included items 3,6,8,17,18 (Appendix C).

The questionnaire items which consisted of traditional non-nursing functions were items 2,4,5,7 and 9. The remaining questionnaire items (1,10,11,12,13,14,15,16,19,20) reflected the new nursing role (See Appendix C, Tables 1-4). An identification of questionnaire items in relation to scales and subscales is found in Table 3.1.

(a) Frequency in performing nursing functions. This scale, measuring frequency in performing selected nursing functions, was selected because it contained many functions characteristic of the expanded role of the ER nurse in caring for the non-urgent patient. This nursing role encompassed the aspects of preventive care, patient and family teaching, and referral (Parker, 1984). The functions were consistent with the new nursing standards established for emergency nursing practice (Appendix A). The scale contains 20 items which equally represented aspects of traditional and expanded nursing roles.

(b) Extent of training. This scale measured nurses' perceptions of the extent of training they possess in performing selected nursing functions. According to Barrows (1985), nurses who had been extensively trained to assess the ER patient were still unable to use new nursing skills in the ER setting. Information from this scale was used to determine whether extent of training influences perceived performance of nursing functions. The 20 questionnaire items used to determine frequency of performing selected functions in this scale examined the nurses' extent of training. A 5-point rating (excellent to minimal) addressed the

Table 3.1
Identification of Items in Relation to Scales and Sub-scales

Scale	Subscale	Items*
A. Frequency in Performance of selected Nursing Functions	1. Non-nursing functions	2,4,5,7,9
	2. Critical Care Functions	3,6,8,17,18
	3. Performance of New Nursing Functions	1,10,11,12,13,14 15,16,19,20
B. Extent of Training	1. Critical Care Functions	3,4,6,8,9,11,12
	2. New Nursing Functions	1,2,5,7,10,13,14 15
C. Need for Additional Knowledge and Skill	1. Critical Care Functions	3,5,9,11
	2. New Nursing Functions	1,2,4,6,7,8,10 12
D. Level of Satisfaction	1. Non-Nursing Functions	1,8,12
	2. Critical Care Functions	5,6,9
	3. New Nursing Functions	2,3,4,7,10,11
	4. General Satisfaction	13,14,15

*Specific items are listed in Appendix C, Tables 1-4.

extent of training as perceived by ER nurses.

(c) Need for additional knowledge and skill. The scale need for additional knowledge and skill is an attitudinal scale which measured the nurses' perceived need for more knowledge and skill in each area of function being performed. Thirteen items were measured on a 4-point rating (very much to none). This information was used to determine adequacy of preparation for performance of ER nursing functions.

(d) Satisfaction with nursing performance. The scale satisfaction with nursing performance is an attitudinal scale which measured the extent to which nurses perceived their performance of certain functions to be satisfying. Fifteen items were measured on a 4-point rating scale (very satisfactory to never do this). The level of satisfaction with one's nursing role may have an effect on the quality and delivery of nursing care being provided (Gray, 1976; Mellett, 1981).

Content and Face Validity

Prior to the main study, a group of 10 emergency nurse experts were selected to critique and validate the questionnaire form for content and face validity. An expert was defined as a nurse who has prolonged experience in emergency nursing, and who was aware of the job description and expectations of the emergency nurse. This group of nurses was not used in the major study to avoid contamination of results. Nurse experts were contacted either in person or by phone and the study was explained to them. A packet including a cover letter, a copy of the questionnaire to be used in

the main study, a copy of the ER nursing standards, a critique form, and a self-addressed, stamped envelope for return of the packets was sent to those agreeing to participate on the panel. Nurse experts were asked to critique the questionnaire as to the importance of each item, consistency of items with nursing standards, and clarity of the wording. When packets were returned, the results of the critique were tabulated, and a 70% level of agreement between nurse experts was attained for all items.

In relation to clarity of wording, nine out of ten nurses agreed that each item in the questionnaire was clearly understood. In relation to importance of each item, nurse experts rated nursing functions "very important" to "important" at a 80-100% level of agreement using a 4 point scale which ranged from "very important" to "not important". An 80-100% level of agreement was reached for non-nursing functions ranging from "not important but frequently necessary" to "not important" on the scale.

Using the criterion of consistency with nursing standards, nurse experts reached a 70-100% level of agreement on question items relating to nursing functions, while a 70-100% level of agreement was reached on those items relating to non-nursing functions that were not consistent with nursing standards. Recommendations of the nurse experts were also used to make modifications to the wording and sentence structure of question items.

Pilot Study

The questionnaire was pilot tested using a group of 15 ER nurses from Eastern Canada who did not participate in the main study. This group of nurses, employed on a full-time basis, functioned under

the same nursing standards as did the nurses in the main study, and a hospital job description indicated that the responsibilities and job expectations were similar in both the pilot and main study groups. The purpose of the pilot study was to detect any unforeseen problems in the research methods and to establish further content and face validity for the instrument (Polit + Hungler, 1978). Nurses were also encouraged to comment and make recommendations on any aspect of the questionnaire so the face validity could be enhanced. Feedback from the nurse experts and comments from the pilot study were used to revise three items prior to administration of the questionnaire in the main study. The term "transport" was substituted for "porter" in item 4 of the first scale and item 12 of the fourth scale, and the term "move" was substituted in place of "shuffle" in item 7 of the first scale.

Data Collection

Data were collected from respondents in the main study by the use of a revised questionnaire. Each subject was given a packet which contained a cover letter with instructions (Appendix B), a questionnaire (Appendix C), and a self-addressed stamped envelope. A code number was also used to distinguish between the three hospitals for purposes of data analysis. All measures to ensure confidentiality and anonymity were carefully outlined to the nurses in the introductory letter.

A three week time period was allotted for return of the completed questionnaires and a follow-up letter was sent out to all nurses as a reminder after the second week (Appendix E). Of 131 questionnaires distributed, 90 were returned (68.7%), all of which

were used in the study. Table 3.2 indicates the percentages of those questionnaires returned from each of the three hospitals.

Statistical Methods

Data compiled from the questionnaires were analyzed using the following statistical methods.

1. Frequency Distribution of Scores and Percentages: Subscales were first descriptively analyzed according to scale categories and frequencies and percentages were calculated.

2. Measures of Central Tendency: In the comparative analysis, means were used to determine an average index in the subscales, and standard deviation was used to establish a measure of variability.

3. Alpha Coefficient: Alpha coefficient was used to estimate internal consistency (reliability) for each subscale.

4. Factory Analysis: Factor analysis (using principle components method and varimax rotation) was used to determine whether nursing functions performed fell into specific categories.

5. Analysis of Variance: This was used to determine whether values from each subscale differed statistically according to the three hospital groups, and also to determine whether differences in biographical variables had an association with performance of selected nursing functions. Student's t test was used to determine whether mean differences existed between degree and non-degree nurses in functions being performed.

Methodological Limitation

Some limitations were imposed on the data due to the ordinal nature of the responses. Data were initially described and

Table 3.2

Percentage of Returned Questionnaires

	Questionnaires		
	Distributed	Returned	
Subjects	Total No.	N	%
Hospital 1	53	37	69.8
Hospital 2	50	36	72.0
Hospital 3	28	17	60.7
Total	131	90	68.7

summarized as an overview of general trends. Many items appeared to yield conflicting information, therefore it was necessary to reduce the data by using subscale rather than item scores. This step allowed for more meaningful comparisons to be made between groups later in the analysis.

CHAPTER IV

RESULTS

The information presented in this chapter is divided into four sections. In the first section a description of the sample is provided. In the second section, an examination of the instrument including reliability and validity is discussed. Thirdly, a descriptive summary of the nursing function questionnaire is presented, and finally a comparative analysis including discussion of the results of ANOVA is presented.

Description of the Sample

A total of 90 registered nurses who were employed on a fulltime or permanent part time basis (16 hours or greater per week) in three city hospital emergency departments participated in the study.

Age of the respondents. The nurses in the sample ranged in age from 22 to 53 years with a mean age of 31.6 years (S.D. 5.89). For the ease of the reader, ages have been grouped into four categories (see Table 4.1). Fourteen percent of respondents were between the ages of 20 and 25 (Group 1); 32% were between 26 and 30 (Group 2); 28% were between 31 and 35 (Group 3); and 26% were age 36 and over. The majority of nurses fell into the 26 to 30 year age group.

Sex of the respondents. Three nurses were male (3.3%) and 87 nurses were female (96.7%), which reflects an expected

Table 4.1

Distribution of Emergency Room Nurses by Age Category

Age Category	Absolute Frequency	Relative Frequency (percent)
20-25	13	14.8
26-30	29	33.0
31-35	25	28.4
36 and over	23	23.8
Total	90	100.0

Table 4.2

Distribution of Emergency Room Nurses by Highest Level of Education Attained

Level of Education	Absolute Frequency	Relative Frequency (percent)
1. Basic Diploma in Nursing	72	80.0
2. Bachelors Degree in Nursing	4	4.4
3. Post-basic Bachelor of Science in Nursing	8	8.9
4. Masters Degree in Nursing	1	1.1
5. Other	5	5.6
Total	90	100

Table 4.3

Distribution of Emergency Room Nurses by Years Worked Since R. N. Licensure

Years Worked	Absolute Frequency	Relative Frequency (percent)
1-5 years	23	25.6
6-10 years	30	33.2
11-15 years	23	25.6
16 years or more	14	15.6
Total	90	100.0

distribution among the two sexes.

Level of education. Seventy two nurses (80.0%) were graduates of an R.N. diploma program (see Table 4.2). According to highest level of education attained, four (4.4%) nurses had a Basic Bachelor of Science in Nursing while 8 (8.9%) nurses had complweted a post-basic Bachelor of Science in Nursing. Of those who reported other training, 5 nurses possessed either a non-nursing university degree or post-graduate training.

Years worked since R.N. licensure. The mean number of years worked for nurses was calculated as 9.8 (S.D. 5.90) years with a range of 1 to 26 years. Data have been grouped into 4 categories (see Table 4.3). Twenty-three nurses (25.6%) have worked 1-5 years; 30 nurses (33.2%) have worked 6 to 10 years; 23 nurses (25.6%) have worked 10 to 15 years, and 14 nurses (15.6%) have worked 16 years or more. Respondents were distributed over all categories with the majority of nurses falling into the 6 to 10 years of work category.

Years worked in present position. For the nurses in the sample, the mean number of years worked in their present positions was 5.1 (S.D. 4.14) years. Interestingly, 38.2% of nurses had worked 2 years or less while 51.7% of nurses had worked 4 years or less in their present position. Respondents have been categorized into four groups (Table 4.4). Fifty-three nurses (58.9%) had worked 1 to 5 years in their present position; 24 nurses (26.7%) had worked 6 to 10 years; 11 nurses (12.2%) had worked 11 to 15 years; and 1

Table 4.4

Distribution of Emergency Room Nurses
by Years Worked in Present Position

Years In Present Position	Absolute Frequency	Relative Frequency (percent)
1 - 5	53	58.9
6 - 10	24	26.7
11 - 15	11	12.2
Over 15	1	1.1
Missing Data	1	1.1
Total	90	100.0

Table 4.5

Distribution of Involvement in
Nursing or Other Organizations

Involvement	Absolute Frequency	Relative Frequency (percent)
Yes	29	32.2
No	61	67.8
Total	90	100

nurse (1.1%) had over 15 years experience.

Involvement in nursing or other organizations. Sixty-one nurses (67.8%) had no involvement while 29 nurses (32.2%) were involved in some organization (see Table 4.5). Nurses were asked to list those organizations in which they were involved. In summary, of 90 nurses, only 8 (8.9%) were involved in their professional emergency nurse organization. Other professional nursing organizations included staff nurse associatons; and audit, charting, and patient care committees. Nurses reported that they also attended staff meetings, inservices, and continuing education courses when available.

Examination of the Instrument

Validity of the Instrument

Construct validity of the scale "frequency in performing selected nursing functions" was assessed to determine whether question items would fall into the categories established earlier in the literature review. Findings from the literature review indicated that functions being performed by the ER nurse fell into three categories. The items within each category are presented in Appendix C (Tables 1-4).

According to Kerlinger (1973), factor analysis can be used to determine a number of underlying variables among many measures. In this study, factor analysis was used to determine whether those items falling into the three categories established by the original researchers, and adapted for this study through the literature review, would hold true in the analysis.

In order to establish construct validity, it was necessary

to assign ordinal values to the response categories (Table 4.6). A score of 1-5 was allocated for each response and factor analysis was then used on the recoded items. Pearson correlation was used to obtain correlation coefficients between items. Factors were initially extracted by use of principle components method, using the usual criterion of eigenvalues greater than one, resulting in a six factor solution which explained 63% of the variance. However, factors five and six included only two significant (> .30) loadings each and no underlying factors could be determined. According to Polit and Hungler (1978) and Kerlinger (1973), the normal cutoff value for a sizeable loading is from .30 to .40. The factor solution was further condensed from five factors down to a two factor solution. Each factor matrix was examined to obtain clear factor configuration and interpretable results. The loadings with three factor solution exhibited the most clear configurations of any of the factors (see Table 4.7). The three factor solution explained 53% of the variance. These factors will be discussed in relation to the nursing function question items under study:

Factor 1. In the first factor, moderate to high loadings were found for variables 3, 8-16, 19 and 20. It appears as though the overall nature of the first factor is related to the expanded role of the ER nurse. Items 10-16 and 19-20 as originally determined from the literature review are all found in this factor. Item 1 "establish a written plan of care for a patient" loaded low on all factors. The low loading may have been attributed to the fact that this function was not being performed by the majority of ER nurses in this study. Item 3 "independently diagnose and initiate care for the acute

Table 4.6
Distribution of Emergency Room Nurses in Performance of Nursing Functions by Scales and Subscales, Alpha Reliability Coefficients, and Scoring of Items*

Scales	Mean	S.D.	Alpha
A. Frequency in Performing Selected Functions Sub-scales			
1. Performance of Non-nursing functions (5 items)	2.6	.68	.56
2. Performance of Critical Care Functions (5 items)	3.5	.61	.60
3. Performance of New Nursing Functions (10 items)	3.0	.67	.81
N.B. Items in this scale were assigned ordinal values and scored as follows:			
5 point rating / score			
3+/day / 1			
1 or 2/day / 2			
2 or 4/week / 3			
1/week - 1/month / 4			
less than 1/month / 5			
B. Extent of Training Subscales			
1. Performance of Critical Care Functions (5 items)	1.9	.70	.83
2. Performance of New Nursing Functions	2.7	.77	.90

Table 4.6
Distribution of Emergency Room Nurses in Performance of Nursing Functions by Scales and Subscales, Alpha Reliability Coefficients, and Scoring of Items
(continued)

Scales	Mean	S.D.	Alpha
Items in this scale were scored as follows:			
5 point rating — score			
Excellent — 1			
Good — 2			
Fair — 3			
Limited — 4			
Minimal — 5			
C. Need for Additional Knowledge and Skill Subscales			
1. Performance of Critical Care Functions (4 items)	2.5	.64	.75
2. Performance of New Nursing Functions (8 items)	2.2	.51	.84
Items in this scale were scored as follows:			
4 point rating — score			
very much — 1			
some — 2			
very little — 3			
none — 4			
D. Level of Satisfaction Subscales			
1. Performance of Non-Nursing Functions (3 items)	3.8	1.0	.75

Table 4.6
Distribution of Emergency Room Nurses in Performance of Nursing Functions by Scale and Subscales, Alpha Reliability Coefficients, and Scoring of Items
(continued)

Scales		Mean	S.D.	Alpha
2.	Performance of Critical Care Functions (3 items)	1.5	.54	.44
3.	Performance of New Nursing Functions (6 items)	2.3	.63	.64
4.	General Satisfaction			
	Authority and Responsibility	2.3	1.0	.38
	Pay	2.3	.96	
	Work	1.9	.80	

Items in this scale were scored as follows:

5 point rating	score
very satisfactory	1
satisfactory	2
not very satisfactory	3
totally unsatisfactory	4
never do this (not included in general satisfaction)	5

*Raw Data is reported in the Questionnaire in Appendix C (Tables 1-4)

Table 4.7
Factor Analysis of Frequency of Performance
of Selected Nursing Functions (20 items)

Rotated Factor Matrix (Varimax)
3 Factor Solution

Variables	Item Description	Factor 1	Factor 2	Factor 3
1	Written care plan	.25	.16	-.16
2	Search for equipment	-.04	*.41	.16
3	Diagnose acute pt.	*.33	.28	*.52
4	Transport patients	.07	*.80	-.09
5	Complete forms	-.02	*.57	-.35
6	ER Defibrillation	.16	.01	*.57
7	Move pts. around ER	.05	*.70	.13
8	Perform ABC's to Acute pt.	*.39	.20	*.36
9	Restock linen	*.46	.26	-.02
10	Obtain history	*.71	-.10	-.14
11	Assess pts health habits	*.80	-.04	.07
12	Obtain info (environment)	*.81	-.04	.03
13	Evaluate other factors	*.77	-.11	.02
14	Counsel about resources	*.61	-.02	.17
15	Construct pt medications	*.41	*.44	.27
16	Perform initial physical	*.43	.25	.23
17	CPR to pt in arrest	-.01	.12	*.70
18	Assist in applying MAST	-.06	-.19	*.73
19	Counsel chronic pt	*.48	.15	.23
20	Counsel chronic on wellness	*.47	.13	.19

* significant loadings $\geq$ .30

patient "loaded highest on factor 3, non-nursing functions. Item 8 "perform the ABC's of ER assessment to the critically ill patient" loaded modestly on both Factors 1 and 3. Item 9, "restocking linen in the ER" also loaded only modestly on Factor 1.

Factor 2. Items which loaded high on this factor appeared to be related to the non-nursing role of the ER nurse. Items 2, 4-5, 7 and 15 contained modest to high loadings and all but item 15 were categorized earlier as part of the ER non-nursing role. Item 15 "instruct a patient about the use of medications" loaded moderately on both Factor 1 and 2.

Factor 3. The 5 items which loaded modest to high on this factor had been identified earlier as the critical care aspects of the ER nurses' role. Items 3, 6, 8, 17, 18 all contained loadings $\geq$ .30.

Variables in this study were viewed in the light of the findings from a literature review documented earlier. Construct validity was attained in that the majority of items factored into the three categories established at the outset of the study.

Nunnally (1967) cautioned readers that the sample used in factor analysis should be ten times the power of the number of variables under study. Similarly, Kerlinger (1973) noted that factors are tentative, subject to later confirmation and may differ as the sample differs. Given the number of subjects in this study (90) and the number of variables (20), further analysis of the constructs using a larger number of subjects would need to be undertaken.

Reliability of the Instrument

Cronbach's alpha coefficient was used to assess the reliability of the three attitude scales and subscales (see Table 4.6, p.44). The purpose was to determine the internal consistency of the instrument. The coefficients for all but 2 subscales ranged from .55 to .90. In the two subscales with low coefficients, "satisfaction with performance of critical care functions" and "general satisfaction," there were only two and three items to each subscale. According to Polit and Hungler (1978) and Nunnally (1967), longer scales are generally more reliable than short item scales, and this may have been a contributing factor.

Descriptive Analysis

Results of Nursing Functions Questionnaire

Data collected from respondents were categorized and analyzed in relation to selected non-nursing functions, critical care nursing functions, new nursing functions and satisfaction with nursing functions. Due to the differences in scales, findings will be discussed in detail for the first scale and a descriptive summary will be provided as an overview for the remaining scales. The raw data containing frequency percentages has been included in Appendix C, (Tables 1-4).

1. Frequency of Performance of Nursing Functions

Selected Non-Nursing Functions

The frequency distribution of performing selected non-nursing functions demonstrates that nurses continue to perform most of these functions on a relatively frequent basis (see Table 4.8). Nurses state they do not search on nursing floors and other

Table 4.8

Distribution of Emergency Room Nurses According to Frequency in Performing Selected Non-Nursing Functions

No.	Question		3+day	1-2/day	2-4/wk	1/wk-1/mo	≤ 1/mo	missing	Total
2.	Search on nursing floors and other areas for missing equipment.	Frequency	1	4	7	19	58	1	90
		Percent	1.1	4.4	7.8	21.1	64.4	1.1	100
4.	Transport patients via stretcher to other hospital areas.	Frequency	27	17	21	20	5		90
		Percent	30.0	18.9	23.3	22.2	5.6		100
5.	Complete requisition forms (lab work for a patient).	Frequency	35	14	16	15	9	1	90
		Percent	38.9	15.6	17.8	16.7	10.0	1.1	100
7.	Move patients and belongings around the emergency department.	Frequency	67	14	4	4	1		90
		Percent	74.4	15.6	4.4	4.4	1.1		100
9.	Restock linen in emergency rooms	Frequency	20	42	17	8	3		90
		Percent	22.2	46.7	18.9	8.9	3.3		100

areas frequently for missing equipment as only 1% reported they perform this activity 3+/day while 64% report they perform the function <1/month. In transporting patients via stretcher to other hospital areas, responses were evenly distributed over all categories except the less than 1/month category where only 5 nurses (6%) performed the function less than once per month. Nurses are performing this function with varying frequency. In completing requisition forms, 39% of nurses are performing this function 3+/day, and 50% of nurses perform the function twice a day to once per week. Nurses continue to move patients and belongings around the emergency department frequently as 74% perform this function 3+/day, and 88% of nurses restock linen from 3+/day to twice per week.

Selected Critical Care Nursing Functions

The frequency distribution of performance of selected critical care nursing functions (Table 4.9) demonstrates that certain critical care functions are not being performed frequently. Nurses do spend time diagnosing and initiating care for an acutely ill patient as 38% of nurses perform the function 3+/day, and 39% perform the function once per day to four times per week. Similarly, 37% nurses perform the ABC's of emergency assessment on an acutely ill patient frequently (3+/day) and 42% perform the function once per day to four times per week. Nurses do not routinely assist in the emergency defibrillation of a patient in that 90% of nurses perform the function less than once per week. Similarly 96% of nurses assist in applying anti-shock trousers in an acutely traumatized patient once per week or less with 60% performing the function less than once per month. In initiating CPR, 49% of nurses perform this function

Table 4.9

Distribution of Emergency Room Nurses According to Frequency in Performing Critical Care Nursing Functions

No.	Question		3+day	1-2/day	2-4/wk	1/wk-1/mo	≤ 1/mo	missing	Total
3.	Independently diagnose and initiate care for a patient with an acute condition based on signs and symptoms.	Frequency	34	20	15	13	8		90
		Percent	37.8	22.2	16.7	14.4	8.9		100
6.	Assist in the emergency defibrillation of a patient who is admitted in full cardiac arrest.	Frequency			9	42	39		90
		Percent			10	46.7	43.3		100
8.	Perform the ABC's of emergency assessment in an acutely ill or injured patient.	Frequency	33	23	15	14	5		90
		Percent	36.7	25.6	16.7	15.6	5.6		100
17.	Respond to a patient who is admitted to the department in full cardiac arrest by initiation of CPR.	Frequency	2	1	11	44	32		90
		Percent	2.2	1.1	12.2	48.9	35.6		100
18.	Assist in applying anti-shock trousers to control bleeding in an acutely traumatized patient.	Frequency			4	34	52		90
		Percent			4.4	37.8	57.8		100

from once per week to once per month with 36% of nurses performing the function less than once per month.

Selected New Nursing Functions

In relation to the frequency in which ER nurses are performing new nursing functions (see Table 4.10), 91% of nurses establish a written plan of care for a patient less than once per month. Nurses frequently obtain a patient's perception of his problem as 60% perform the function once per day to 3+/day. Similarly, 68% of nurses frequently assess a patient's general health habits. Obtaining information about the physical environment or the home is not performed as frequently as 72% of nurses perform this function four times a week or less. In evaluating economic and other factors which affect the patient's health, 63% of nurses perform this function less than once per week. Nurses counsel a patient about available community resources with moderate frequency in that 61% of nurses perform the function from once per day to four times per week. In instructing a patient about the use of medications, 88% of nurses perform the function once per day to 3+/day. Similarly, 64% of nurses perform an initial physical assessment of the non-critical patient frequently (3+/day). Nurses do not counsel and teach a patient or family about chronic illness frequently as 64% of nurses perform this function under once a week. Additionally, nurses do not frequently counsel a patient on obtaining a sense of wellness in the presence of a chronic condition as 77% of nurses perform this function less than once per week.

Table 4.10

Distribution of Emergency Room Nurses According to Frequency in Performing Selected New Nursing Functions

No.	Question		3+day	1-2/day	2-4/wk	1/wk-1/mo	≤ 1/mo	missing	Total
1.	Establish a written plan of care for a patient with a presenting complaint.	Frequency	3			3	82	2	90
		Percent	3.3			3.3	91.1	2.2	100
10.	Obtain as part of a history, a patient's perception of his problem and how it affects his life.	Frequency	36	18	9	19	8		90
		Percent	40.0	20.0	10.0	21.1	8.9		100
11.	Assess a patient's general health habits.	Frequency	47	14	13	10	6		90
		Percent	52.2	15.6	14.4	11.1	6.7		100
12.	Obtain information about the physical environment of the home and community.	Frequency	5	20	25	22	18		90
		Percent	5.6	22.2	27.8	24.4	20.0		100
13.	Evaluate economic, religious, and cultural factors for their impact on family and community health.	Frequency	8	12	13	31	26		90
		Percent	8.9	13.3	14.4	34.4	28.9		100

Table 4.10
(continued)

No.	Question		3+day	1-2/day	2-4/wk	1/wk-1/mo	< 1/mo	missing	Total
14.	Counsel a patient about available community resources that might be relevant to his needs.	Frequency	2	20	33	22	13		90
		Percent	2.2	22.2	36.7	24.4	14.4		100
15.	Instruct a patient about the use of medications.	Frequency	60	19	6	5			90
		Percent	66.7	21.1	6.7	5.6			100
16.	Perform an initial physical examination in assessment of the non-critical patient.	Frequency	58	8	8	8	6	2	90
		percent	64.4	8.9	8.9	8.9	6.7	2.2	100
19.	Counsel and teach a patient and/or family about the nature of his chronic condition.	Frequency	6	7	19	32	26		90
		Percent	6.7	7.8	21.1	35.6	28.9		100
20.	Counsel a patient on ways of obtaining a sense of wellness in the presence of a chronic condition.	Frequency	2	5	14	31	38		90
		Percent	2.2	5.6	15.6	34.4	42.2		100

2. Extent of Training in Performance of Selected Nursing Functions

Critical Nursing Functions

Nurses were unanimous in their agreement that their training in the area of critical care functions was good to excellent on all items even though they had indicated they were not performing some selected critical care functions frequently. For example, 87% of nurses reported their training in the area of assisting in ER defibrillation of a patient was fair to excellent even though 90% of nurses performed the function under once per week.

Selected New Nursing Functions

Nurses indicated that their extent of training in the overall performance of selected new nursing functions is only fair. Areas in which over 50% of respondents described the extent of their training as fair to minimal included establishing a written plan of care (Item 1), obtaining the patient's perception of the problem (Item 5), evaluating the impact of economic, religious and cultural factors on the patient and family (Item 8), and counselling a patient about a chronic condition (Items 14 and 15). In other areas, for example obtaining a patient's problem and how it affects his/her life, nurses were equally divided in responses as 47% felt their training was moderate and 54% felt it was adequate.

3. Need for Additional Knowledge and Skills in Performance of Selected Nursing Functions

Critical Care Nursing Functions

Emergency nurses feel there is some need for further knowledge in the area of critical care nursing functions. Thus, even though these nurses were not performing critical functions frequently

and indicated, by their responses, that overall their training in performing critical nursing functions was appropriate, they still perceived a need for more knowledge. In particular they expressed a need in the area of drawing up treatment and management plans for the acutely ill patient as 66% of nurses reported "some need" to "very much need".

Selected New Nursing Functions

Responses by nurses to questions relating to need for additional knowledge and skill indicated that nurses perceived some need for knowledge in all selected new nursing functions. In particular, 87% of respondents indicated that they perceived a need to know more about ways to motivate a patient to practice preventive health care and 76% of respondents requested more knowledge in the giving of health information as well as to evaluate the patient's family and home setting (70%). Of the nurses in this study, 77% indicated that there is only "some" to "no" need for additional knowledge regarding establishment of written care plans; however, they also stated that their training in this area is only fair and they perform this function less than once per month.

Need for Other Knowledge and Skills

Respondents were asked to list areas where they felt more knowledge and skill would be beneficial. Nurses expressed a strong need for more knowledge in the area of cardiology including advanced cardiac life support, and interpretation of ECG's and arrythmias. Secondary to this need was more knowledge in the area of multi-system trauma, ongoing education regarding general management of the medical patient, ongoing drug updates including intravenous therapy, and care

of the psychiatric patient. Those areas of less priority but still rated important included stress management, application of the nursing process to the ER; including physical assessment of the ER patient and discharge teaching, and areas of general anatomy and physiology for review.

4. Satisfaction with Performance of Selected Nursing Functions

Non-Nursing Functions

The data related to satisfaction with performance of selected non-nursing functions showed that the nurses were not satisfied with non-nursing functions being performed and were especially dissatisfied with the task of restocking linen where 82% of respondents indicated they were "not very satisfied" to "totally unsatisfied" with the need to perform this function.

Critical Care Nursing Functions

The nurses in this study indicated that they were extremely satisfied with performing critical care nursing tasks as 84-100% of nurses were "satisfied" or "very satisfied" performing these functions. They had also indicated their training in performing critical care functions was "excellent" even though they performed the functions "relatively infrequently".

Selected New Nursing Functions

The ER nurses generally reported satisfaction with performance of new nursing functions. Nurses appear to be reasonably satisfied performing new nursing functions with the exception of the establishment of a written plan of care in which 27% of nurses reported dissatisfation with the task, and 53% of nurses reported it was not being done.

General Job Satisfaction

Nurses were asked to respond to three items related to their level of job satisfaction. Of the respondents, 84% were satisfied with the amount of authority and responsibility that went with the job. Nurses were also reasonably satisfied with the pay they received with 79% of respondents indicating they were either "satisfied" or "very satisfied". Finally, nurses were asked to rate their overall job satisfaction, where 90% of respondents reported they were "satisfied" to "very satisfied" with their role and functions in the Emergency Room.

Results of the Comparative Analysis

Subscales were assigned scores and the scores for each rating scale were then averaged. This step allowed for further comparisons to be made between nurse groups in relation to the variables under study (see Table 4.6).

For the first scale, ordinal values of 1-5 were assigned for scoring purposes, as the intervals were obviously unequal. The second scale "extent of training in the performance of nursing functions" was given a 5 point rating which ranged from excellent (scored 1) to minimal (scored 5). The third scale "need for additional knowledge and skills" was given a 4 point rating ranging from very much (scored 1) to none (scored 4). Similarly, the fourth scale satisfaction with performance of nursing functions" was given a 5 point rating which ranged from very satisfactory (scored 1) to totally unsatisfactory (scored 5). Subscale scores were then determined by averaging the rating scales.

Summary of Data Presented in Table 4.6

The mean scores presented in this data are arbitrary in that

they do not reflect a true interval value. The scores establish the central tendency of respondents in relation to the categories on the rating scales. In the second scale, extent of training, respondents indicated their training in the area of critical care nursing functions was good. They evaluated their level of training in the area of new nursing functions to be only fair as indicated by a mean of 2.74 (S.D. .767). In the area of need for additional knowledge and skill, respondents reported some need to have more information in the area of critical care functions ($\bar{x}$ 2.49, S.D. .644). Similarly they expressed some need, though not as great, in the area of new nursing functions indicated by a mean of 2.17 (S.D. .506). In relation to level of satisfaction, the respondents rated the critical care functions above the level of the "satisfactory" category with a mean of 1.58 (S.D. .544). In relation to new nursing functions, they reported satisfaction with a mean of 2.32 (S.D. .628). Regarding non-nursing functions, nurses reported extreme dissatisfaction indicated by a mean of 3.77 (S.D. 1.028). In relation to authority and responsibility, nurses reported satisfaction with a mean of 2.26 (S.D. 1.02). Similarly they are satisfied with their salary ($\bar{x}$ 2.29, S.D. .961) and are in general satisfied with their work with a mean of 1.86 (S.D. .799).

Effect of the Biographical Variables on Performance of Selected Nursing Functions

Analysis of variance was performed to determine whether differences existed between nurses in functions being performed according to educational level, age, and years worked since R.N. licensure.

Educational Level of Respondents

Of the sample, 72 nurses graduated from a diploma nursing program, and 18 nurses were prepared at the university level with one nurse possessing a masters degree (see Table 4.2). Due to the large group size discrepancy, the total ssample was divided into degree and diploma categories. Student's t test revealed an association ($\leq$ .05) between degree and diploma nurses in the area of satisfaction with performance of non-nursing functions (see Table 4.11). The higher mean seen with the diploma level nurses indicated these nurses were more dissatisfied with their non-nursing role than were the degree nurses.

Age of the Respondents

No significant differences were seen when selected nursing functions were compared among age groups.

Years Worked Since R.N. Licensure

Four categories were used to group nurses according to years worked since R.N. licensure (see Table 4.3). In the area of need for additional knowledge and skill (Table 4.12), there was an association between nurses working 1-5 years and those nurses working 16 years or more in the performance of new nursing functions ($p \leq .05$). Further, the Scheffé Multiple Comparison test (Table 4.13) revealed that the significant differences were primarily due to the difference between nurses who worked longest in years and those nurses who had been at the job for a shorter time period (1-5 years). Those nurses working longer expressed a greater need for additional knowledge and skill regarding performance of new nursing functions.

Table 4.11

Student's t Test Performed on Emergency Room Nurses According to Level of Education in the Satisfaction with Performance of Non-Nursing Functions

Group	Freq.	Mean	S.D.	T Value	df
1. Degree	18	10.77	3.16	*-2.80	88
2. Non-Degree (Diploma)	72	12.94	1.77		
Total	90				

*Denotes a significant difference between groups $\leq .05$.

Table 4.12

Analysis of Variance Performed on Emergency Room Nurses According to Years Worked Since R.N. Licensure and the Need for Additional Knowledge and Skill in Performance of New Nursing Functions

Source	D.F.	Sum of Squares	Mean Squares	F
Between Groups	3	3.24	1.08	*4.77
Within Groups	86	19.50	.23	
Total	89	22.74		

*Denotes a significant difference between groups $\leq$ .05 level

Table 4.13

Scheffé Test to Determine Significant Mean Differences Between Nurse Groups According to Years Worked Since R.N. Licensure

Years Worked Since R.N. Licensure	Frequency	Mean	Standard Deviation
1-5 (Group 1)	23	2.41*	.389
6-10 (Group 2)	30	2.21	.468
11-15 (Group 3)	23	2.07	.465
16+ (Group 4)	14	1.88*	.624
Total	90	2.17	.505

*Denotes significance at the .05 level

Hospital Variation

Analysis of variance was performed on each of the subscales to determine whether differences existed between the three hospitals. Nurses in three hospitals were compared on four variables: frequency in performing nursing functions, extent of training, need for knowledge and skills, and satisfaction with job functions. No mean differences were found between the three groups on any variables with the exception of performance of non-nursing functions (see Table 4.14). The Sheffé test further revealed that the differences were attributed to hospital one and three and hospital two and three in the performance of non-nursing functions (Table 4.15).

Nurses perform non-nursing functions more frequently in hospital three than nurses in either hospital one or hospital two. Nurses in this hospital comprise the smallest portion of the total sample and the hospital itself is considerably smaller in bed capacity. It is possible that there are fewer support personnel and that nurses are expected to assume more non-nursing functions in smaller less active emergency facilities.

Table 4.14

Analysis of Variance Performed on Emergency Room Nurses by Hospital According to Frequency of Performing Selected Non-Nursing Functions

Source	D.F.	Sum of Squares	Mean Sqaures	F
Between Groups	2	5.01	2.50	6.14*
Within Groups	87	35.50	.41	
Total	89	40.51		

*Denotes significance at ∝ .05 level

Table 4.15

Scheffé Test to Determine Significant Mean Differences Between Nurses According to Hospital

Hospital Group	Frequency	Mean	Standard Deviation
1	37	#2.65	.621
2	36	2.79*	.703
3	17	#2.14*	.519
Total	90	2.61	.674

#*Denotes significance of pairs of groups at ∝ .05 level

CHAPTER V

SUMMARY DISCUSSION, AND CONCLUSIONS

The purpose of this study was to examine and to describe the role(s) and functions that the ER nurse is presently performing. The instrument used to measure these functions consisted of two parts, a biographical questionnaire and a nursing function questionnaire.

Information from respondents regarding age, sex, level of education, number of years worked since R.N. licensure, number of years in present position, and whether respondents attended or sat on any committees in a professional nursing organization or other organization was obtained using the biographical questionnaire.

The second part of the instrument, a four part questionnaire measuring frequency of performance of selected nursing functions, extent of training, need for additional knowledge and skill, and satisfaction with emergency nursing was administered to 140 subjects. A response rate of 67.8% was achieved. The subjects were drawn from the Emergency Room staff of three general hospitals in Western Canada.

Summary Characteristics of the Sample

The ages of respondents ranged from 22-53 years of age with a mean age of 31.6 (S.D. 5.89) years. All but 3 of the respondents were female. The majority of nurses were graduates of a basic nursing diploma program (80.0%) and the remainder of nurses

were graduates of a basic, post-basic or masters degree program (20.0%). The mean number of years worked since R.N. licensure was 9.8 (S.D. 5.90) years with a range of 1-26 years. The mean number of years worked in present positions was 5.1 (S.D. 4.14) years. Of 90 nurses, 67.8% had no involvement in any professional nursing organization or other organization. Only 8.9% of nurses were professionally affiliated with their emergency nursing association. This latter finding is consistent with the work of Andreoli and Musser (1985) who found that of 60,000 nurses, only 22% were members of the Emergency Nurses Association. They concluded, as did Parker (1984), that emergency nurses suffered from professional lethargy as indicated by the small number of nurses professionally affiliated with their emergency nursing organization.

Summary of the Findings

In summary, nurses in this sample ranged from 22 to 53 years of age with a mean of 31.6 years. Only three respondents were male, the remainder being female. The majority of nurses were graduates of a basic nursing diploma program (80.0%) and the remainder of nurses were graduates of a bsic, post-basic, masters degree program or other (20.0%). In relation to the number of years worked since licensure, the range was 1-26 years with a mean of 9.8 (S.D. 5.90) years. For number of years worked in present position, the mean was 5.1 (S.D. 4.14) years although slightly over 50% of nurses had worked 4 years or less. Of the total nursing sample, 67.8% of nurses had no involvement in any professional nursing or other organization, and only 8.9% of nurses were involved in their professional emergency

nursing organization.

It appears that the ER nurses continue to perform many non-nursing functions frequently, especially moving patients around the ER and restocking linen. Further, many critical care functions were not performed frequently such as initiation of CPR, application of anti-mast trousers, and assisting in emergency defibrillation. Nursing in this sample rarely prepare written care plans, evaluate all factors affecting a patient's health frequently, or teach and counsel a patient about chronic illness or obtaining a sense of wellness in the presence of a chronic condition with any great frequency.

Nurses reported that their extent of training with regard to performance of critical care functions was good to excellent; however, they felt that their extent of training in performance of new nursing functions was only fair.

The nurses expressed a need for more knowledge in the area of critical care and in the area of performance of new nursing functions. When asked to list areas where more knowledge would be beneficial, nurses expressed a strong need for more information in the area of cardiology, in multi-system trauma, and in the general management of the medical patient.

The nurses did not appear to be satisfied performing non-nursing functions. In contrast, nurses performing critical care functions were extremely satisfied with their work and were somewhat satisfied with their performance of new nursing functions. In the area of general satisfaction, nurses stated that they were satisfied with both the authority and the responsibility of the job as well as

with the pay, and all things being equal, were generally satisfied with the functions they were presently performing.

It appears that an association exists between degree and non-degree nurses with satisfaction in performance of non-nursing functions. Nurses who had worked the longest in years since R.N. licensure expressed a significantly greater need for additional knowledge and skill in performing new nursing functions than did those nurses who had worked only a few years at their job.

Further, an association was seen between hospital groups in the performance of nursing functions. Nurses from hospital three performed non-nursing functions more frequently than did nurses in either hospital one or two.

Validity of the Instrument

Construct validity of the scale to measure the volume and the type of selected nursing functions was assessed by examining whether question items would cluster into three categories as suggested in the literature review. To this end, a factor analysis was carried out, and a three factor solution was obtained. The solution explained 53% of variation.

The overall nature of the first factor was related to the expanded role of the ER nurse. Items 3,8-16, and 19, 20 all loaded moderate to high on this factor.

Factor 2 appeared to be related to the non-nursing aspects of the ER nurse role. Item 15 "instruct a patient about the use of medications" loaded moderately on Factor 1 and 2. Nurses, though performing this function frequently, may at the same time perceive the role to be pharmacy-related.

Those items with modest to high loadings on Factor 3 all appeared to be related to the critical care aspects of the nurse's role. Those items were 3,6,8,17 and 18. The first item "establishment of a written plan of care" loaded low on all factors and it was determined in the study that nurses are rarely preparing care plans. The third item "independently diagnose and initiate care for the acute patient" loaded highest on Factor 3, critical care nursing functions. Respondents may have believed this responsibility was more medically related. Similarly the item "perform the ABC's of emergency assessment" loaded modestly on Factors 2 and 3. The item may have loaded on Factor 3 due to the fact that the function is part of the initial triage process carried out on any patient. Item 9 "restocking of linen" loaded modestly on Factor 1 and was perceived to be a function performed by all nurses.

Generally, construct validity was attained in that the majority of items did factor into three categories established at the outset of the study. The items that did not load as expected would either need to be reworded or removed before the tool was used for sbusequent study and construct validity would need to be re-established.

Reliability of the Instrument

Reliability of the three attitude scales and subscales was assessed by use of Cronbach's alpha coefficient. The coefficients for all but 2 subscales ranged from .55 to .90. The two subscales with low reliability were satisfaction with performance of critical care functions ($r = 0.44$), and "general satisfation" ($r = 0.38$). It is possible that the size of these two subscales containing two

question items, the other containing three question items. According to Polit and Hungler (1978) and Nunnally (1967), a longer scale usually results in a stronger reliability.

Discussion of Results

The research questions addressed in this study will be discussed and related to the findings as well as to the literature review. The first question relates to the extent ER nurses perceive they are performing selected nursing functions. The second question concerns the ER nurses' perceptions of the extent of their training in the performance of selected nursing functions. The third question related to ER nurses' perceptions of the adequacy of their training in performing selected nursing functions, and the fourth question concerns the ER nurses' perceived satisfaction in performing certain nursing functions.

Frequency of Performance of Selected Nursing Functions

Based on an extensive literature review, emergency nursing functions were categorized into three groups: non-nursing functions, critical care functions, and new or expanded nursing functions. Several authors documented the great extent to which ER nurses were performing non-nursing functions (Gray, 1976; Mellett, 1981; Parker, 1984). The findings of this study demonstrate that nurses continue to perform non-nursing tasks frequently. Part of the ER nurse's role has traditionally included care for the urgent or emergent patient (Jones, Yoder, Jones, 1984). It was the concern of these authors that nurses were undergoing a role dilemma because they preferred their critical care role, despite the fact that the critically ill patient was becoming more and more uncommon. The ER nurses in this

study were not performing critical care functions frequently, which supports the contention of Jones, Yoder and Jones, (1984) that the acuity of care in the ER was decreasing. The nurses were also not performing many new or expanded functions frequently. For example, nurses stated that they establish a written plan of care for a patient less than once a month. Additionally, they do very little counselling with patients in relation to their chronic disease or about obtaining a sense of wellness even though the chronically ill now constitute a good portion of the emergency patient population. Recent nursing standards for the ER nurses (Emergency Department Nurses Association, 1983), include the formulation of a nursing care plan as a vital part of the role of an ER nurse. Findings indicate that nurses perceive they regularly spend time obtaining patient histories and in instructing patients regarding medication use. Both of these functions were established as being part of the new nursing role.

Extent of Training in Performing Selected Nursing Functions

Nurses in this study were unanimous in their agreement that their level of training in performing critical care functions was good to excellent even though they performed such functions relatively infrequently. They did not perceive that they were well trained in performing an assessment of the patient's physical or non-physical needs which supports the earlier work of Barrows (1983). Nurses do not perceive their training as adequate in the area of establishing written care plans, making referrals to available community resources, or in counselling the chronically ill patient. Perhaps the reluctance of nurses to care for the non-urgent patient

as documented by Jones, Yoder, and Jones (1984) and Yoder and Jones (1981), is due to the fact that nurses have not had adequate training for performing such tasks. Earlier studies done by Fincke (1974) and Romano (1975, 1978), documented similar findings in that nurses stated that they had not been given the opportunity to upgrade knowledge and skills for a changing nurse's role.

Need for Additional Knowledge and Skill in Performing Selected Nursing Functions

When questioned about the need for additional knowledge in relation to critical care nursing functions, nurses indicated there was some need for more knowledge even though they indicated their training was excellent. The area in critical care with the highest need priority for nurses was in the drawing up of treatment and management plans for the acutely ill patient. Similarly, nurses expressed a need for more knowledge in the area of new nursing functions, specifically in ways to motivate patients to practice preventive health care, and in the giving of health information. Additionally, they felt more knowledge was needed in evaluating the patient's home and family setting. Surprisingly, nurses expressed very little need to learn more about the establishment of nursing care plans which, according to the literature, must become an integral part of the nurse's role.

An open-ended question at the end of this sub-scale was used to determine whether nurses had a need for more knowledge in other areas. The majority of nurses expressed a need for further learning in the areas of cardiology, including advanced life support, interpretation of cardiac arrythmias, and ECGs. Second, nurses

expressed a need for more information in the area of general systems trauma, management of the medical patient, and drug therapy updates. Other areas of need included care of the psychiatric patient, stress management, and application of the nursing process to the ER including assessment of the ER patient.

Satisfaction with the Performance of Selected Nursing Functions

Nurses were asked to rate their level of satisfaction with regard to non-nursing functions. The majority were not satisfied with the performance of non-nursing tasks but were performing them frequently. Conversely, nurses were extremely satisfied with the critical care aspects of their ER nurse role. The high level of satisfaction among nurses with regard to critical care functions was well supported in the literature (Burns, Kirilloff + Close, 1983; Jones, Yoder + Jones, 1984; Lewis + Bradbury, 1983; Mytych, 1983). In the performance of new nursing functions, nurses were somewhat satisfied with their role with the exception of nursing care plans. According to the results of this study, the majority of nurses do not establish written care plans for any ER patient.

In general, nurses are satisfied with the authority and responsibility that goes with the job, and are reasonably satisfied with their salaries. All things considered, nurses are satisfied with their role as ER nurses.

Level of Education, Age, and Years of Experience Worked in Relation to Performance of Selected Nursing Functions

Biographical data were used to determine whether differences in means existed among various groups of nurses regarding functions being performed. It was revealed that an association between degree

and non-degree nurses in the area of satisfaction with performance of non-nursing functions did exist. No difference in average scale scores between nurses could be attributed to age; however, in relation to number of years of experience since licensure, there was an association between nurses working for 16 years or more and new graduates (with 1-5 years of experience) in the area of need for additional knowledge and skill in performance of new nursing functions. Nurses who had worked longer expressed a greater need for more knowledge which would probably be attributed to the fact that those nurses were trained to perform traditional ER nursing roles which were to care for the critical or urgent patient.

Variation by Hospital

Three hospitals were compared to determine whether differences existed in nursing functions being performed. An association did appear in the area of non-nursing functions between hospital one and three and hospital two and three. In hospital three, the nurses performed non-nursing functions more frequently than nurses in either hospital one or two.

Conclusions

Several conclusions in regard to ER nurses' functions may be drawn from this study. Firstly, nurses continue to perform non-nursing functions frequently (often greater than three times per day), but express dissatisfaction in performing these non-nursing tasks.

Secondly, ER nurses do not regularly perform certain critical care tasks (often less than once per month) but are extremely satisfied with their critical care role. Nurses expressed

a need for additional knowledge and skill in the area of critical care although at the same time they feel their training in this area has been excellent.

Thirdly, nurses are performing some new or expanded nursing functions one to three times per day. In the area of written care plans, they state that this function is clearly not being performed. Nurses also stated they had a need to know more about the care of the chronically ill patient.

Lastly, nurses performing new nursing functions thought their training had been inadequate in the area of referral to community agencies, counselling the chronic patient, and establishment of written care plans. They expressed a need for additional knowledge and skill in ways to motivate patients to practice preventive health care, in evaluating the patient, home and family setting, and in the giving of health information. They expressed only very little need to learn more about written care plans for the ER patient. An association was seen between nurses in the area of years worked since R.N. licensure and the need for additional knowledge and skill in that nurses working longer expressed a greater need for increased knowledge in performing new nursing functions. Also, in relation to frequency of performance of non-nursing functions, nurses from hospital three performed non-nursing functions with greater frequency than did nurses in hospital one or two.

Role of the ER Nurse

Due to changing health care needs, the roles and functions of the ER nurse have broadened. In this study, nurses continue to

practice their traditional ER nursing role. Non-nursing activities continue to be a part of the ER nurse role, although the functions are not a particularly satisfying aspect of the nurses' job. Critical care nursing is not frequently performed by the ER nurses, but the nurses state their critical care role provides strong feelings of satisfaction. New nursing functions are being performed by ER nurses to some extent.

In summary, ER nurses continue to perceive their role as a traditional nursing role consisting of frequent performance of non-nursing functions and occasional care of the critically ill patient. It appears that the ER nurses are in the process of broadening their role to care for the non-urgent patients by assuming many of the new functions. Some areas for further education were cited which could help nurses better adapt to their changing role.

Implications for Improving Emergency Room Nursing

Probably the most significant area for improvement in the delivery of nursing is in the re-education of the ER nurse for a changing nursing role. Findings from the study revealed several areas where re-education is needed. Nurses are expressing a considerable need for increased knowledge and skill in both the area of critical care and in the area of new nursing functions. Recent statistics reveal that the largest majority of users of the ER facilities are the non-urgent patients. It is possible that the ER nurses are requesting more information about the critical care aspects of their role because it is a role which is seldom being used. Over the past few years paramedics have been used to stabilize the critically ill patient during transport to the ER setting. Thus

nurses may not use critical care skills as frequently as in the past. Due to larger numbers of non-urgent patients and the increased availability of the ER nurse to provide care, it is not unexpected that ER nurses would request more knowledge in the area of new nursing functions. The nurses specifically requested additional preparation in areas related to the care of the chronic patient, and counselling the ER patient toward obtaining a sense of wellness. Another area where nurses may need more information lies in the area of ER nursing standards. More specifically, nurses need to become more familiar and knowledgeable about the establishment of written care plans which is said to be a vital aspect of the new ER nursing role. There is widespread documentation of the use of care plans in many Emergency Room facilities in the U.S.A., although there was no literature available on the establishment of care plans in Canada. In the literature, it was documented that nurse accountability and accreditability, as well as the legality of practice, was strongly linked to the need for care plan implementation. There appeared to be strong support for the use of the "standardized care plan" containing basic information related to the care of all patients who are admitted with a particular condition. With a standardized plan for care, space is provided on the sheets for additional details specific to each patient. Nurses in this study, however indicated that they had little interest in increasing their knowledge in relation to nursing care plans. They also indicated that they did not use care plans in the ER. Generally, the nurses had an ongoing need for continuing education in several areas including management of the psychological and physical needs of the ER patient and in

application of the nursing process in the ER.

Nurses continue to perform non-nursing functions frequently which may have implications for the nurse administrator. Patient care could be improved if nurse availability to the patient was increased. Nurses could then perform new responsibilities in a wider time frame.

As emergency nursing continues to gain recognition as a specialty, ER nurses must become more unified and better represented in their professional organization. Nurses must become more knowledgeable and assertive in their need for continued education in order to provide care to a changing ER clientele in an accountable professional manner.

Limitations and Recommendations

Several problems were identified as the study was conducted and the following recommendations might be a consideration should further research with the tool occur:

Limitations

1. Although reliability of the tool was established, modifications are needed in the scales. Two subscale reliability coefficients were low due to small numbers of subscale items. No overall reliability could be established as the questionnaire contained four scales which measured different aspects of the ER nurses role.

2. The nominal/ordinal nature of the scales forced some limitations on the data when the initial analysis was carried out, specifically the first part of the questionnaire "frequency in the performance of nursing functions." In the first scale, it was

necessary to assign ordinal values so that factor analysis could be used to assess construct validity. With the remaining scales which measured nurse attributes, interval scale qualities were assigned so that some association testing could be done.

3. Factor analysis was performed on one scale to assist in validating the instrument. Not all items loaded on the factors as expected, therefore further studies are needed to determine whether nursing functions do in fact fall into categories used in the original Vacek et al scale, and adapted using categories established through the literature review.

Recommendations

1. Because the survey method of the target population does not necessarily result in a representative sample, there is a need for a comparative description of the functions being performed by ER nurses in a variety of settings. For example, studies could be of survey, comparative, or other nature and nurses could be sampled from rural hospitals, teaching hospitals where nurses have joint appointments, or general "inner city" hospitals.

2. The addition of a time motion study, would assist the investigator in determining what functions the ER nurse is performing and what ratio of time is being spent on each function. Another consideration might be that of a prospective study on frequencies with which nurses are performing selected nursing functions. Specifically, the investigator or nurses themselves would be asked to record frequencies over a set period of time in which functions are being performed.

3. A pre-study on the "in house" characteristics of the

hospitals under study might contribute some information relating to the nature of the ER patient population which could consequently have an effect on the role of the ER nurse.

4. Further studies using provincial demographic data on nurses employed in emergency settings could be used to compare the study sample against the general nurse population. This would establish whether the study sample was representative of the target population of ER nurses.

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APPENDICES

APPENDIX A:

Standards of Emergency Nursing Practice

Standards for Emergency Nursing Practice
Emergency Department Nurses' Association (EDNA)

Practice

Standards

I. Assessment
II. Analysis
III. Planning
IV. Intervention
V. Evaluation
VI. Communication

Research

Standards

I. Recognize and value research as a methodology to further emergency nursing practice.

Education

Standards

I. Provision of information.

II. Education of self and peers.

III. Emergency nurse shall assist the patient and significant others to obtain knowledge about illness, injury prevention and treatment.

Emergency Nursing Practice
Standard Components

I. Assessment: Accurate and ongoing assessment of physical/psychosocial problems of patients
   A. Assessment includes systematic and pertinent collection about health status of patient (history taking, physical exam, review of records)
   B. Data Collection - data collected and recorded periodically as appropriate to the nature and severity of illness
   C. Triage

II. Analysis: Analysis of assessment data to form diagnosis
   A. Data base formulation - A nursing diagnosis shall be formulated for all patients.
   B. Data organization - Data shall be organized in a systematic manner to coordinate relevant activities with other team members

III. Planning: Formulation of a comprehensive care plan for the ER patient
   A. Priority setting - All patients evaluated according to health needs
   B. Standardized care plans: Used as a systematic, uniform, and consistent method to provide safe and effective care

IV. Intervention: Implementation of a plan of care
   A. Independent function - competent skill performance and clinical judgement
   B. Comfort
   C. Coping
   D. Aftercare and referral - verbal and written instructions regarding aftercare and a source of referral for follow-up care

V. Evaluation - plan of care evaluated and/or modified based on observable responses
   A. Quality Assurance
   B. Audit

VI. Communication - open and timely communication with emergency patients, significant others, and team members
   A. Patient and Family liaison
   B. Community liaison
   C. Documentation

*Note. From Emergency Department Nurses Association (1983). Standards for Emergency Nursing Practice, St. Louis, C. V. Mosby Co.

Standards of Emergency Nursing Practice
National Emergency Nurses' Affiliation (NENA)*

Standard II: The Nursing Process

Components

1. Emergency nurses collect data of physical and psycho-social problems within the emergency care system on an initial and continuous basis.
   - data collected consistent with nature of difficulty, severity of health problem, and urgency needed for intervention

2. Emergency nurses analyze data to formulate a nursing diagnosis.

3. Emergency nurses plan nursing actions based upon the actual and potential nursing diagnoses and collaborate with other members the formulation of an overall care plan (teaching, counselling, informing, providing care and comfort measures).
   - includes in plan, provision of knowledge to patient and relevant others about illness, injury, prevention, and
   - identifies required resources in a plan of action treatment
   - develops a written plan of action and makes it available to others involved in the care of the patient

4. Emergency nurses implement the plan of action consistent with independent, interdependent, and dependent functions.
   - encourages patient participation in the implementation of the plan of action
   - assists the patient and relevant others to acquire knowledge about illness, prevention of injury, and treatment

5. Emergency nurses evaluate all aspects of the nursing process in accordance with a conceptual model for emergency nursing consistent with independent, interdependent, and dependent functions.
   - judges the degree to which outcomes have been achieved giving consideration to patient participation
   - revises with the patient and relevant others the nursing diagnosis, nursing action plans, and priorities as indicated.

*Note. From National Emergency Nurses' Affilation, (1986). Standards of Emergency Nursing Practice: Toronto.

APPENDIX B:

Cover Letter to Participants

M. N. Candidate
Lorna Bell
199 Palmdale Drive
Williamsville, NY 14221

Phone: Edmonton (403) 454-5329
New York (716) 626-0428

Faculty Supervisor
Dr. P. A. Field
3-118 Clinical Sciences
Faculty of Nursing
University of Alberta
Edmonton, Alberta
Phone: (403) 432-6248

Dear Registered Nurse:

I am a graduate nursing student at the University of Alberta. In order to complete requirements for a Masters Degree, I am conducting a study dealing with nurses' perception of the functions they perform in the Emergency Room. and their satisfaction with the job they are performing. This study has come out of my observations over the eleven years I have worked as an emergency nurse.

If you agree to participate in the study you will be required to answer a questionnaire. Your voluntary completion and return of the questionnaire will signify your consent. You are under no obligation to complete the questionnaire. Whether you choose to participate or not will not be known by your employer and will in no way effect your employment. The questionnaire will take only 20 minutes of your time to complete.

There is no risk to you in this research. No individual information will be given to employers although they will have access to the final report which

will consist of results reported as group data. The code number on the front of the questionnaire differentiates between the three hospitals I am using for my study. Individual respondents cannot be identified through this code, therefore the researcher will not be able to determine which nurses answered the questionnaire. All data will be coded and grouped for purposes of analysis.

A self-addressed, stamped envelope has been provided for the return of the questionnaire with the researcher's name and address on the front. In order to maintain confidentiality of information, please be sure to seal it so that no one can read your responses. I ask that you return the completed questionnaire in the provided envelope within the next three weeks.

If you have any questions about the study or the questionnaire packet, I am available at the phone number on the left of the first page. Additionally, my faculty supervisor's phone number has been placed on the right side of the page, if you are unable to contact me.

The benefit of this study will not be apparent immediately. I will share my results with you after the study is completed. Hopefully the study will enlighten us as to the perceptions of our fellow nurses regarding their daily work activities. You will be sent a reminder

one week before the deadline for submission of the questionnaire.

Thank you in advance for your time and cooperation.

Sincerely,

Lorna M. Bell

LMB:vls

APPENDIX C:

Questionnaire

01

QUESTIONNAIRE
ER Nurses' Perceptions of their Role(s) and Functions in the Emergency Room

A. Biographical Data

Please fill out the following:

1. What is your age? _____

2. What is your sex? (Please circle one.) M F

3. Indicate the level of education you have attained. (Please circle all that apply.)

   a) R.N. Diploma
   b) Basic Bachelor of Science in Nursing
   c) Post-R.N. Bachelor of Science in Nursing
   d) Master's Degree (Nursing)
   e) Other (Please specify) _____

   _____

4. How many years have you worked since R.N. licensure?
   _____

5. How many years have you worked in your present position?
   _____

6. Do you presently attend meetings or sit on any committees in a nursing organization(s) or other organization(s)? (Please circle one.)

   Yes No

   If Yes, please specify: _____

   _____

B. Nursing Functions*

The remainder of the questionnaire addresses nursing functions. Please read each question carefully. In the adjacent column, indicate which answer best indicates the way you actually practice in your emergency unit. Do not provide an answer which indicates the way you think nurses should practice nor the way you would like them to practice.

Do not place your name or any number on any part of the questionnaire or the envelope.

I. Frequency in Performing Selected Nursing Functions

This section addresses the extent to which you are presently performing selected nursing functions. Check the appropriate box in each set. If you never perform a certain task, check the box for "less than 1/month."

Example:

	I perform this function the following number of times.				
	3+/day	1 or 2/day	2 or 4/week	1/week-1/month	less than 1/month
Perform a bladder catherization on a female patient.	☐	☐	☑	☐	☐

Table C.1. Scale Items for Frequency of Performing Selected Functions with Frequency of Response

	Functions	I perform this function the following number of times				
		3+/day	1 or 2/day	2 or 4/week	1/week-1/month	less than 1/month
		Percentage of Respondents Answering at Each Level				
	1. Establish a written plan of care for a patient with a presenting complaint.	3	—	—	3	93
**	2. Search on nursing floors and other areas for missing equipment (e.g. stretchers).	1	5	8	21	65
*	3. Independently diagnose and initiate care for a patient with an acute condition based on signs and symptoms (e.g. asthmatic in distress).	38	22	17	14	9
**	4. Transport patients via stretcher to other hospital areas.	30	19	23	22	6
**	5. Complete requisition forms (e.g. laboratory work for a patient).	39	16	18	17	10
*	6. Assist in the emergency defibrillation of a patient who is admitted in full cardiac arrest.	—	—	10	47	43

Functions	I perform this function the following number of times				
	3+/day	1 or 2/day	2 or 4/week	1/week-1/month	less than 1/month
	Percentage of Respondents Answering at Each Level				
** 7. Move patients and belongings around the emergency department.	74	16	4	4	1
* 8. Perform the ABCs (airway, breathing, circulation) of emergency assessment in an acutely ill or injured patient.	37	26	17	16	6
** 9. Restock linen in emergency rooms.	22	47	19	9	3
10. Obtain as part of a history, a patient's perception of his problem and how it affects his life.	40	20	10	21	9
11. Assess a patient's general health habits.	52	16	14	11	7
12. Obtain information about the physical environment of the home and community.	6	22	28	24	20
13. Evaluate economic, religious, and cultural factors for their impact on family and community health.	9	13	14	34	29

Functions	I perform this function the following number of times				
	3+/day	1 or 2/day	2 or 4/week	1/week-1/month	less than 1/month
	Percentage of Respondents Answering at Each Level				
14. Counsel a patient about available community resources that might be relevant to his needs.	2	22	37	24	14
15. Instruct a patient about the use of medications (e.g. mode of action, possible side effects).	67	21	7	6	—
16. Perform an initial physical examination in assessment of the non-critical patient.	66	9	9	9	7
* 17. Respond to a patient who is admitted to the department in full cardiac arrest by initiation of CPR (cardiopulmonary resuscitation).	2	1	12	49	36
* 18. Assist in applying anti-shock trousers (MAST) to control bleeding in an acutely traumatized patient.	—	—	4	38	58

Functions	I perform this function the following number of times				
	3+/day	1 or 2/day	2 or 4/week	1/week-1/month	less than 1/month
	Percentage of Respondents Answering at Each Level				
19. Counsel and teach a patient and/or family about the nature of his chronic condition.	7	8	21	36	29
20. Counsel a patient on ways of obtaining a sense of wellness in the presence of a chronic condition.	2	6	16	34	42

*** Items relate to Traditional Critical Care Nursing Functions.**
**** Items relate to Traditional Non-Nursing Functions.**
Non-starred items identify the New Nursing Functions.

Table C.2 Scale Items for Extent of Training with Frequency of Response

II. Extent of Training

The second section addresses the extent to which you feel you are trained to perform any of the listed functions as part of your present employment. In evaluating your level of training, please check the appropriate box in each set.

	My training in this area has been				
	excellent (1)	good (2)	fair (3)	limited (4)	minimal (5)
Example					
Perform a bladder catheterization on a female patient.	☐	☐	☐	☑	☐

Function	Percentage of Respondents Answering at Each Level				
1. Establish a written plan of care for a patient with a presenting complaint.	☐ 9	☐ 32	☐ 17	☐ 14	☐ 28
* 2. Independently diagnose and initiate care for a patient with an acute condition based on signs and symptoms (e.g. asthmatic in distress).	☐ 30	☐ 50	☐ 19	☐ 1	☐ —
* 3. Assist in the emergency defibrillation of a patient who is admitted in full cardiac arrest.	☐ 34	☐ 38	☐ 15	☐ 7	☐ 4

Functions	My training in this area has been				
	excellent	good	fair	limited	minimal
	Percentage of Respondents Answering at Each Level				
* 4. Perform the ABCs (airway, breathing, circulation) of emergency assessment in an acutely ill or injured patient.	49	39	12		
5. Obtain as part of a history, a patient's perception of his problem and how it affects his life.	16	38	30	11	6
6. Assess a patient's general health habits.	11	56	27	2	4
7. Obtain information about the physical environment of the home and community.	6	34	31	21	8
8. Evaluate economic, religious, and cultural factors for their impact on family and community health.	8	22	29	22	19
9. Counsel a patient about available community resources that might be relevant to his needs.	1	34	37	20	8

Functions	My training in this area has been				
	excellent	good	fair	limited	minimal
	Percentage of Respondents Answering at Each Level				
10. Perform an initial physical examination in assessment of the non-critical patient.	31	44	13	7	5
* 11. Respond to a patient who is admitted to the department in full cardiac arrest by initiation of CPR (cardio- pulmonary resuscitation).	59	24	11	6	
12. Assist in applying antishock trousers (MAST) to control bleeding in an acutely traumatized patient.	28	36	23	10	3
13. Instruct a patient about the use of medications (e.g. side of action, possible side effects).	28	57	13	1	1
14. Counsel and teach a patient and/or family about the nature of his chronic condition.	3	39	36	13	9

Functions	My training in this area has been				
	excellent	good	fair	limited	minimal
	Percentage of Respondents Answering at Each Level				
15. Counsel a patient on ways of obtaining a sense of wellness in the presence of a chronic condition.	4	22	31	26	17

***Items relate to Traditional Critical Care Nursing Functions**
Non-starred items identify the New Nursing Functions

Table C.3 Scale Items for Need for Additional Knowledge and Skills with Frequency of Response

III. Need for Additional Knowledge and Skills

The third section addresses the need for additional knowledge and skills. In your practice setting, how much need is there for you to obtain more knowledge and skills about . . .

	Percentage of Respondents Answering at Each Level			
	very much (1)	some (2)	very little (3)	none (4)
1. Obtaining information from patients about their illness and health history?	8	42	39	11
2. Doing a physical examination in assessment of the non-critically ill patient?	10	48	33	9
* 3. Assisting in the emergency defibrillation of a patient who is admitted in full cardiac arrest.	10	41	32	17
4. Assessing the patients' general health status?	6	46	42	7
* 5. Helping to draw up treatment and management plans for acutely ill patients?	16	50	31	3
6. Helping to prepare treatment and management plans for patients who have chronic illnesses? (i.e. heart disease, cancer, stroke, mental illness)	22	43	28	7
7. Evaluating patients' family and home setting?	14	56	27	3
8. Ways of motivating patients to practice preventive health care?	28	54	16	2

	Percentage of Respondents Answering at Each Level			
	very much	some	very little	none
* 9. Performing the ABCs (airway, breathing, circulation) of emergency assessment in a seriously ill or injured patient?	11	30	41	18
10. Ways of giving health information?	19	57	20	4
* 11. Assisting in application of anti-shock trousers (MAST) to control bleeding in a traumatized patient?	7	53	22	18
12. Establishment of a written plan of care for a patient with a presenting complaint in the ER.	22	35	22	20

13. Are there other knowledge and skills you would like to gain via workshops, etc.? Please list them according to priority.	Yes	No
	☐	☐

1. _____
2. _____
3. _____

***Relates to Traditional Critical Care Nursing Functions**
Non-starred items identify the New Nursing Functions

Table C.4 Scale Items for Satisfaction with Nursing Functions and Frequency of Response

IV. Satisfaction with Nursing Functions

The fourth section addresses satisfaction with nursing functions. Please check whether you find the following activities very satisfactory, satisfactory, not very satisfactory, totally unsatisfactory, or never do this.

		very satisfactory	satisfactory	not very satisfactory	totally unsatisfactory	never do this
		Percentage of Respondents Answering at Each Level				
**	1. Completion of requisition forms (e.g. patient's laboratory work).	10	27	34	23	6
	2. Obtaining health information from patients.	31	70	___	___	___
	3. Doing a physical examination on a non-critical patient.	17	70	10	1	2
	4. Your role in preparing treatment and management plans for the chronically ill patient.	12	37	36	1	14
*	5. Performing the ABCs (airway, breathing, circulation) of emergency assessment in the seriously ill or injured patient.	66	34	___	___	___
*	6. Your role in preparing treatment and management plans for the acutely ill patient.	40	44	11	1	3

	very satisfactory	satisfactory	not very satisfactory	totally unsatisfactory	never do this
	Percentage of Respondents Answering at Each Level				
7. Establishment of a written plan of care for a patient with a presenting complaint.	___	21	21	5	53
** 8. Restocking linen in emergency rooms.	3	14	28	52	2
* 9. Responding to a patient who is admitted to the department in full cardiac arrest by initiation of CPR (cardiopulmonary resuscitation).	63	31	4	1	1
10. Practicing preventive health care.	18	53	25	2	1
11. Providing health education to patients with chronic conditions.	11	49	31	4	5
** 12. Transporting patients via stretcher to other hospital areas.	2	23	38	36	1
*** 13. The amount of authority and responsibility you have.	18	60	20	1	___

		very satisfactory	satisfactory	not very satisfactory	totally unsatisfactory	never do this
		Percentage of Respondents Answering at Each Level				
***	14. The pay you receive.	12	67	19	1	
***	15. All things considered, how satisfied are you with your work?	31	59	8	1	

***Items relate to Traditional Critical Care Nursing Functions**
****Items relate to Traditional Non-Nursing Functions**
*****Items relate to General NursingSatisfaction**
Non-starred items identify the New Nursing Functions

APPENDIX D:

Permission to Use the Instrument

The University of Vermont

MEDICAL BIOSTATISTICS, COLLEGE OF MEDICINE
GIVEN BUILDING, BURLINGTON, VERMONT 05405-0068
(802) 656-2526

November 24, 1985

Lorna Bell
199 Palmdale Dr.
Williamsville, NY 14421

Dear Ms. Bell

You are most welcome to use our questionnaire "Nursing Roles in Ambulatory Patient Care" for your Master's Degree research. We would only request that you acknowledge us as the source of this instrument in your thesis and any other publications that may ensue from its use.

Good luck in your research endeavors.

Sincerely,

Pamela M. Vacek

Pamela M. Vacek

An Equal Opportunity Employer

APPENDIX E:

Follow-Up Letter

M. N. Candidate

Lorna Bell
199 Palmdale Drive
Williamsville, NY 14221

Phone: Edmonton (403) 454-5329
New York (716) 626-0428

Faculty Supervisor

Dr. P. A. Field
3-118 Clinical Sciences
Faculty of Nursing
University of Alberta
Edmonton, Alberta
Phone: (403) 432-6248

Follow Up Letter

Dear Registered Nurse:

This is a follow-up letter to remind you that the questionnaire packet, if you choose to participate, should be returned within the next week. As I indicated in my original letter, I have no way of identifying participants. Therefore, if you have already returned the packet, I wish to take this opportunity to thank you for participating in my study. If you have mislaid the questionnaire but would like to participate, please contact me at the Edmonton phone number given above.

On completion of the study, I would be happy to present my findings at an inservice session in the emergency department. I will also provide the ER with a report of my study.

Once again, thank you for your willingness and cooperation in this study.

Sincerely yours,

Lorna M. Bell, R.N.
M.N. Candidate

LMB:vls